Psychodynamic Psychiatry

in Clinical Practice

Fifth Edition

Glen O. Gabbard, M.D.

PSYCHODYNAMIC PSYCHIATRY IN CLINICAL PRACTICE

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GLEN O. GABBARD, M.D.

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To my teachers, my patients, and my students

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ABOUT THE AUTHOR

Glen O. Gabbard, M.D., is Professor of Psychiatry at State University of New York—Upstate Medical University, Syracuse, New York, and Clinical Professor of Psychiatry at Baylor College of Medicine in Houston, Texas. He is also Training and Supervising Analyst at the Center for Psychoanalytic Studies in Houston, and he is in private practice at The Gabbard Center in Bellaire, Texas.

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PREFACE TO THE FIFTH EDITION

This new edition of *Psychodynamic Psychiatry in Clinical Practice* is appearing 9 years after the fourth edition. Since I first starting writing this text a quarter century ago, this is the longest span of time between revisions. Both American Psychiatric Publishing and I felt it was best to postpone this fifth edition until DSM-5 was in wide circulation. As always, I wanted the chapter organization to be compatible with the DSM-5 categories, even though I do not agree with all of the decisions made by the DSM-5 work groups. My major concern is that the DSM-5 system widely taught to trainees is deliberately atheoretical, and I want to help clinicians find a way to keep psychodynamic thinking alive in their work with patients. We must not lose the complexities of the person if we are to help our patients to the fullest. As Hippocrates once noted, "it is more important to know the person with the illness than the illness the person has." Hence, after the usual introductory chapters in Section I that update the reader on matters of theory, evaluation, formulation, and forms of psychotherapy, I have reorganized the subsequent chapters so that they are simpatico with the DSM-5 categories.

In some cases I added discussions of new entities, such as the application of psychodynamic thinking to the treatment of patients on the autism spectrum in Chapter 13. I also removed certain discussions from the text so that I could keep the length of the textbook more or less the same as the last edition in the service of keeping costs down. In Chapter 10 I included both posttraumatic stress disorder and dissociative disorders so that the chapter was based on the primary psychiatric disorders related to trauma and stressors. Because DSM-5 abolished the multiaxial system endorsed in DSM-IV, I have eliminated all references to the various axes. Those responsible for the final version of DSM-5 chose to keep personality disorders the same as in DSM-IV, but they no longer reside on a separate axis. This new development has both positive and negative implications, in my opinion. On the one hand, it undoes the problem of marginalizing personality disorders on a sep-

arate axis (as though they do not carry the same importance to psychiatrists as all of the other psychiatric disorders). On the other hand, the special recognition of the role of the personality in psychiatry may be diminished somewhat without an axis that calls particular attention to that domain.

In preparing this version of the text, I collected relevant material over many years since the fourth edition in 2005 so I could systematically update each chapter. In fact, all 19 of the chapters have new references and new material as a result. As noted above, material has been deleted as well to keep the length manageable. In an era of reductionism in society as a whole and in medicine in particular, I have tried to keep the life of the mind alive. Dynamic psychiatrists must be biopsychosocial thinkers even if our emphasis is on such matters as internal conflict, the impact of trauma on one's thinking, unconscious fantasies, internal object relations, self structures, and defense mechanisms. Hence, we are guardians of a "flame" that reminds us that we are far more than our genome or our neurocircuitry. The emphasis of the psychodynamic clinician is on what is unique and idiosyncratic about each of us as well as what neurobiology brings to bear on that unique stamp and how the environment influences the brain.

As always, I have a great debt to my trainees at Baylor College of Medicine and State University of New York–Upstate Medical University in Syracuse, whom I have been privileged to teach in recent years. Just as a psychotherapist's best teachers are his or her patients, students are the best teachers of educators. This edition of the book reflects my continued learning from my young trainees, who will be future colleagues. I also wish to express my deep gratitude to those at American Psychiatric Publishing who have supported me through nearly 30 years in my efforts to communicate my ideas to clinicians throughout the world. *Psychodynamic Psychiatry in Clinical Practice* has now been translated into 11 languages and is used as a textbook worldwide. I owe special thanks to Rebecca Rinehart, Robert Hales, John McDuffie, Greg Kuny, and Bessie Jones for all the help they have provided me in the production of this book. Jill Craig in Houston has meticulously prepared new versions of the manuscript with an efficiency that is remarkable. Finally, I wish to express my appreciation to my family, and particularly to my wife, Joyce, who throughout the production of five different editions of this textbook has provided me the support, time, and space necessary to concentrate on the integration of an enormous amount of information in a relatively brief time.

Glen O. Gabbard, M.D.
Bellaire, Texas

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SECTION I

BASIC PRINCIPLES AND TREATMENT APPROACHES IN DYNAMIC PSYCHIATRY

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CHAPTER 1

BASIC PRINCIPLES OF DYNAMIC PSYCHIATRY

> It would be far easier if we could avoid the patient as we explore the realm of psychopathology; it would be far simpler if we could limit ourselves to examining the chemistry and physiology of his brain, and to treating mental events as objects alien to our immediate experience, or as mere variables in impersonal statistical formulae. Important as these approaches are for the understanding of human behavior, they cannot alone uncover or explain all the relevant facts. To see into the mind of another, we must repeatedly immerse ourselves in the flood of his associations and feelings; we must be ourselves the instrument that sounds him.
>
> *John Nemiah, 1961*

Psychodynamic psychiatry (used interchangeably with dynamic psychiatry in this volume) has a diverse set of ancestors, including Leibniz, Fechner, the neurologist Hughlings Jackson, and Sigmund Freud (Ellenberger 1970). The term *psychodynamic psychiatry* generally refers to an approach steeped in psychoanalytic theory and knowledge. Modern psychodynamic theory has often

been viewed as a model that explains mental phenomena as the outgrowth of *conflict*. This conflict derives from powerful unconscious forces that seek expression and require constant monitoring from opposing forces to prevent their expression. These interacting forces may be conceptualized (with some overlap) as 1) a wish and a defense against the wish, 2) different intrapsychic agencies or "parts" with different aims and priorities, or 3) an impulse in opposition to an internalized awareness of the demands of external reality.

Psychodynamic psychiatry has come to connote more than the conflict model of illness. Today's dynamic psychiatrist must also understand what is commonly referred to as the "deficit model" of illness. This model is applied to patients who, for whatever developmental reasons, have weakened or absent psychic structures. This compromised state prevents them from feeling whole and secure about themselves, and as a result they require inordinate responses from persons in the environment to maintain psychological homeostasis. Also contained within the purview of psychodynamic psychiatry is the unconscious internal world of relationships. All patients carry within them a host of different mental representations of aspects of themselves and others, many of which may create characteristic patterns of interpersonal difficulties. These representations of self and others form a world of largely unconscious internal object relations.

Today's psychodynamic clinician can no longer practice a type of psychiatry divorced from the body and sociocultural influences. Indeed, psychodynamic psychiatry must be regarded today as situated within the overarching construct of *biopsychosocial* psychiatry. Dramatic progress in genetics and neuroscience has paradoxically strengthened the position of the psychodynamic psychiatrist. We now have more persuasive evidence than ever before that much of mental life is unconscious, that social forces in the environment shape the expression of genes, and that the mind reflects the activity of the brain. We now practice in a situation of "both/and" rather than "either/or." Although it is true that all mental functions ultimately are products of the brain, it does not follow that the biological explanation is the best or most rational model for understanding human behavior (Cloninger 2004; LeDoux 2012). Contemporary neuroscience does not attempt to reduce everything to genes or biological entities. Well-informed neuroscientists focus on an integrative rather than a reductive approach and recognize that psychological data are just as valid scientifically as biological findings (LeDoux 2012).

Above all, psychodynamic psychiatry is a *way of thinking*—not only about one's patients but also about oneself in the interpersonal field between patient and treater. In fact, to characterize the essence of dynamic psychiatry, one might well use the following definition: *Psychodynamic psychiatry is an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distor-*

tions of intrapsychic structures, and internal object relations and that integrates these elements with contemporary findings from the neurosciences.

This definition raises a challenge to the psychodynamic clinician. How does one integrate the domain of mind with the domain of brain? Psychiatry has moved well beyond the Cartesian notion of substance dualism. We recognize that mind is the activity of the brain (Andreasen 1997) and that the two are inextricably linked. To a large extent, references to mind and brain have become a form of code for different ways to think about our patients and their treatment (Gabbard, 2005). Presumed polarities such as genes versus environment, medication versus psychotherapy, and biological versus psychosocial are often glibly subsumed under the categories of brain and mind. These dichotomies are problematic and tend to break down when we study clinical problems in psychiatry. Genes and environment are inextricably connected in shaping human behavior. The promise of the human genome and "personalized medicine" has not been fulfilled. Terms such as *heritability* have become increasingly meaningless and reductive in light of the environmental influence on genes (Keller 2011). The flurry of initial excitement about personalized medicine as genomics-based knowledge has begun to be challenged by a series of critiques. Horwitz et al. (2013), for example, refer to this trend as "de-personalized medicine" because without environmental, social, and clinical considerations that affect disease outcomes, genomics information is disappointing. The "person" needs to be taken into account. Experience shuts down the transcriptional function of some genes while turning others on. Psychosocial stressors, such as interpersonal trauma, may have profound biological effects by changing the functioning of the brain. Furthermore, thinking of psychotherapy as a treatment for "psychologically based disorders" and medications as a treatment for "biological or brain-based disorders" is a specious distinction. The impact of psychotherapy on the brain is well established (see Gabbard 2000).

An illustrative example of how interpersonal trauma has far-reaching effects on both the biology and the psychology of the "person" emerges from recent imaging research on adults who had experienced childhood abuse (Heim et al. 2013). In a controlled study, those individuals who had experienced sexual abuse as children had cortical thinning in the genital representation field of the primary somatosensory cortex, that is, in the "homunculus" where different body areas are represented. One can infer that neural plasticity of this nature may protect the child from the sensory processing of specific abuse experiences, but it might leave the individual "numb" in the genital area as an adult. This subjective experience will in turn shape how the young person integrates sexuality into the sense of an adult self, an example where a "deficit" based in biology might contribute to psychological conflict in the course of development.

When we depart from the polarization of mind and brain and view the patient as a human being in a biopsychosocial context, we are nevertheless faced with the problem that mind and brain are not identical. Our minds certainly reflect the activity of the brain, but mind cannot be reduced to neuroscientific explanations (Edelson 1988; LeDoux 2012; McGinn 1999; Pally 1997; Searle 1992). The use of functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) technologies has led to quantum leaps in our understanding of brain functioning. Nevertheless, there is a risk inherent in these technologies if we equate the self with what we see on a brain scan. The scanning technologies provide a convenient way to externalize problems by saying that there is something wrong with "my brain" instead of something wrong with "me" (Dumit 2004).

If we acknowledge that mind and brain are not identical, what is the difference? To begin with, the brain can be observed from a third-person perspective. It can be removed from the skull and weighed at autopsy. It can be dissected and examined under a microscope. The mind, on the other hand, is not perception based and therefore can be known only from within. The mind is private. Rather than resorting to an outmoded form of substance dualism, contemporary psychiatrists and neuroscientists often use the construct of *explanatory dualism* (Kendler 2001). This type of dualism acknowledges that there are two different ways of knowing or understanding that require two different kinds of explanations (LeDoux 2012). One type of explanation is first person and psychological, whereas the other type is third person, or biological. Neither approach provides a complete explanation by itself. To complicate matters further, as Damasio (2003) points out, "Consciousness and mind are not synonymous" (p. 184). In a variety of neurological conditions, abundant evidence demonstrates that mind processes continue even though consciousness is impaired.

In the preface to this volume I made the point that we integrate "brain" and "mind" in the service of knowing the "person." After all, it is a person who comes for help. But what is the *person?* A dictionary definition would tell us it is the actual self or being. However, defining the self is not a simple task, either. It is complicated because it is both subject and object. In the sentence "I think about myself," there is both a phenomenal "I" that philosophers write about and a conscious representation of the self. Certainly, another aspect of the self is the aggregate of personal memories that are filtered through the individual's unique lens on the basis of meanings that are highly personalized. Moreover, parts of the self are hidden from us—we are more likely to be conscious of the desirable parts of the self while repressing or disavowing parts we do not like so much. One of the lessons of dynamic psychiatry is that we are all masters of self-deception. Most of us do not know ourselves that well. One further complication is that there isn't one mono-

lithic self. Most of us have multiple facets of the self that are triggered by different contexts. Culture is one of those contexts. Asian culture, for example, is not centered in self-experience, and an *interdependent self* is created by parenting that focuses on social context (Jen 2013).

The next complication we encounter in trying to define what exactly we mean by the *person* is that the *self* and the *person* are not the same thing. The distinction can be illustrated by dividing the subjectively experienced self from the self observed by others. When people see themselves on videotape, they are rarely pleased. They think to themselves, "I don't look like that," or "My voice doesn't sound that way!" However, if they ask others in the room, they will be told that in fact they do look and sound that way. The truth is simple: we don't see ourselves as others see us. Which is the truer version of the self: the subjectively experienced self or the observed self? The question cannot be adequately answered because both are essential in order to know who the *person* is. Each is incomplete: we cannot see how we come across to others, but others cannot always perceive how we feel inside. Knowledge of one's personhood requires an integration of the inside and the outside perspectives.

To summarize, the *person* defies easy categorization. It involves what is unique and idiosyncratic—a complex amalgam of multiple variables. Here are some of the principal determinants of the *person:*

1. The subjective experience of oneself based on a unique historical narrative that is filtered through the lens of specific meanings
2. A set of conscious and unconscious conflicts (and the associated defenses), representations, and self-deceptions
3. A set of internalized interactions with others that are unconsciously reenacted, creating impressions in others
4. Our physical characteristics
5. Our brain as a product of genes in interaction with environmental forces and the creation of neural networks by cumulative experience
6. Our sociocultural background
7. Our religious/spiritual beliefs
8. Our cognitive style and capacities

Throughout this text, in our pursuit of the person, psychological explanations are emphasized, but neurobiological underpinnings also are noted and areas of integration between the psychological and the biological are stressed. The domain of mind and the domain of brain have different languages. The modern dynamic psychiatrist must strive to be bilingual—the language of brain and language of mind must both be mastered in the service of knowing the *person* and providing optimal patient care (Gabbard, 2005).

Although dynamic psychotherapy is one of the foremost tools in the dynamic psychiatrist's therapeutic armamentarium, dynamic psychotherapy is not synonymous with dynamic psychiatry. The dynamic psychiatrist uses a wide range of treatment interventions that depend on a dynamic assessment of the patient's needs. Dynamic psychiatry simply provides a coherent conceptual framework within which all treatments are prescribed. Regardless of whether the treatment is dynamic psychotherapy or pharmacotherapy, it is *dynamically informed*. Indeed, a crucial component of the dynamic psychiatrist's expertise is knowing when to avoid exploratory psychotherapy in favor of treatments that are less threatening to the patient's psychic equilibrium.

Today's dynamic psychiatrists must practice in the context of impressive advances in the neurosciences. The practice setting is also characterized by a vast array of cultural, religious, ethnic, and racial groups whose cultural experiences are internalized and profoundly affect the way they think and feel and the manifestations of whatever psychiatric symptoms may emerge. Hence, a contemporary dynamic psychiatrist is constantly striving to integrate psychoanalytic insights with biological understanding of illness and cultural factors that influence the end result of "the person." Nevertheless, all dynamic psychiatrists are still guided by a handful of time-honored principles derived from psychoanalytic theory and technique that provide psychodynamic psychiatry with its unique character.

The Unique Value of Subjective Experience

Dynamic psychiatry is further defined by contrasting it with descriptive psychiatry. Practitioners of the latter approach categorize patients according to common behavioral and phenomenological features. They develop symptom checklists that allow them to classify patients according to similar clusters of symptoms. The patient's subjective experience, except as used to report items in the checklist, is less important. Descriptive psychiatrists with a behavioral orientation would argue that the patient's subjective experience is peripheral to the essence of psychiatric diagnosis and treatment, which must be based on observable behavior. The most extreme behavioral view is that behavior and mental life are synonymous (Watson 1924/1930). Moreover, the descriptive psychiatrist is primarily interested in how a patient is *similar to* rather than *different from* other patients with congruent features.

In contrast, dynamic psychiatrists approach their patients by trying to determine what is unique about each one—how a particular patient *differs* from other patients as a result of a life story like no other. Symptoms and behaviors are viewed only as the final common pathways of highly personalized subjec-

tive experiences that filter the biological and environmental determinants of illness. Furthermore, dynamic psychiatrists place paramount value on the patient's internal world—fantasies, dreams, fears, hopes, impulses, wishes, self-images, perceptions of others, and psychological reactions to symptoms.

Descriptive psychiatrists approaching an occluded cave nestled in the side of a mountain might well describe in detail the characteristics of the massive rock obstructing the cave's opening, while dismissing the interior of the cave beyond the rock as inaccessible and therefore unknowable. In contrast, dynamic psychiatrists would be curious about the dark recesses of the cave beyond the boulder. Like the descriptive psychiatrists, they would note the markings of the opening, but they would regard them differently. They would want to know how the cave's exterior reflected the inner contents. They might be curious about why it was necessary to protect the interior with a boulder at the opening.

The Unconscious

Continuing with our cave metaphor, the dynamic psychiatrist would figure out a way to remove the boulder, enter the dark recesses of the cave, and, perhaps with a flashlight, illuminate the interior. Artifacts on the floor or markings on the wall would be of special interest to the explorer because they would shed light on the history of this particular cave. A steady gurgling of water coming up through the floor might suggest an underground spring applying pressure from below. The dynamic psychiatrist would be particularly interested in exploring the depths of the cave. How far into the mountainside does it extend? Is the back wall the true limit that defines the inner space, or is it a "false wall" that gives way to even greater depths?

As the cave metaphor suggests, a second defining principle of dynamic psychiatry is a conceptual model of the mind that includes the unconscious. Freud (1915/1963) recognized two different kinds of unconscious mental content: 1) the preconscious (i.e., mental contents that can easily be brought into conscious awareness by merely shifting one's attention) and 2) the unconscious proper (i.e., mental contents that are censored because they are unacceptable and therefore are repressed and not easily brought into conscious awareness).

Together, the unconscious, the preconscious, and the conscious systems of the mind compose what Freud (1900/1953) termed the *topographic model*. He became convinced of the unconscious because of two major pieces of clinical evidence: dreams and parapraxes. Analysis of dreams revealed that an unconscious childhood wish was usually the motivating force of dreams.

The dreamwork disguised the wish, so analysis of the dream was necessary to discern the true nature of the wish. *Parapraxes* consist of such phenomena as slips of the tongue, "accidental" actions, and forgetting or substituting names or words. A typist, for example, repeatedly typed "murder" when she intended to type "mother." The notion of the "Freudian slip" is now a thoroughly entrenched part of our culture that connotes the unwitting revelation of a person's unconscious wishes or feelings. Freud (1901/1960) used these embarrassing incidents to illustrate the breakthrough of repressed wishes and to demonstrate the parallels between the mental processes of everyday life and those of neurotic symptom formation.

The dynamic psychiatrist views symptoms and behaviors as reflections, part, of unconscious processes that defend against repressed wishes and feelings, just as the boulder protects the contents of the cave from exposure. Moreover, dreams and parapraxes are like the artwork on the walls of the cave—communications, symbolic or otherwise, in the present that deliver messages from the forgotten past. The dynamic psychiatrist must develop sufficient comfort with this dark realm to explore it without stumbling.

Another primary way that the unconscious manifests itself in the clinical setting is in the patient's nonverbal behavior toward the clinician. Certain characteristic patterns of relatedness to others set in childhood become internalized and are enacted automatically and unconsciously as part of the patient's character. Hence, certain patients may consistently act deferentially toward the clinician, whereas others will behave in a highly rebellious way. These forms of relatedness are closely linked to Squire's (1987) notion of procedural memory, which occurs outside the realm of conscious, verbal, narrative memory.

Studies of memory systems have greatly expanded our knowledge of behavior in the clinical setting. A widely used distinction that is relevant to psychodynamic thinking is the differentiation of memory into explicit (conscious) and implicit (unconscious) types.

Explicit memory can be either *generic*, involving knowledge of facts or ideas, or *episodic*, involving memories of specific autobiographical incidents. Implicit memory involves observable behavior of which the subject is not consciously aware. One type of implicit memory is *procedural* memory, which involves knowledge of skills, such as playing the piano and the "how to" of social relatedness to others. The unconscious schemas referred to as internal object relations are to some extent procedural memories that are repeated again and again in a variety of interpersonal situations. Another type of implicit memory is *associative* in nature and involves connections between and among words, feelings, ideas, people, events, or facts. For example, one may hear a particular song and feel inexplicably sad because that song was playing on the radio when news of a family member's death arrived.

The notion that much of mental life is unconscious is often challenged by critics of psychoanalysis but has been extensively validated by literature from experimental psychology (Westen 1999a, 1999b). Research subjects who have bilateral lesions to the hippocampus have great difficulty learning that two discrete events are connected, but their emotional responses suggest that they have made an unconscious connection between the two events (Bechara et al. 1995). Subliminal presentation to research subjects of stimuli that have emotional or psychodynamic meanings has been shown to influence a wide range of behavior, even though the subjects have no conscious awareness of the stimuli (Weinberger and Hardaway 1990). Studies of brain event-related potentials demonstrate that emotional words evoke different electroencephalogram alpha waves than do neutral words even before they are consciously recognized. In one study, a team of clinicians assessed which conflicts were relevant to identified patient symptoms. Words reflecting those conflicts were then selected and presented both subliminally and supraliminally to the patients (Shevrin et al. 1996). Different patterns of response were documented for those words consciously related to the patient's symptoms and those hypothesized to be unconsciously related.

Studies revealing unconscious racist tendencies have been particularly impressive validations of the role that the unconscious plays in an ongoing way in human interactions. Much of the data on this phenomenon have stemmed from the Implicit Association Test, which uses pictures of black and white faces flashed before subjects along with positive and negative descriptive adjectives (Banaji and Greenwald 2013). The researchers found that even when subjects intended to associate positive descriptions with black faces as quickly as they did with white faces, they were unable to do it. From these studies, it appears that about 75% of Americans have an unconscious, automatic preference for whites over blacks. A similar percentage is prone to stereotype by gender, sexual orientation, age, body weight, disability, and nationality.

The 2008 Presidential election brought forth yet another demonstration of unconscious mental functioning. Galdi et al. (2008) developed a computer-based, speedy categorization task assessing automatic mental associations. They compared the associations to self-report measures to assess consciously endorsed beliefs and preferences. The automatic associations of the politically undecided participants predicted changes in consciously reported beliefs and featured choices over a period of 1 week. The researchers found that those who were consciously undecided had often already made up their minds at an unconscious level. The investigators noted that even on important matters of political choice, people seemed to be unaware of their own unawareness. They would give reasons for their preferences, but these reasons were clearly confabulatory. Even when people did not know why they had voted the way they did, when asked, they rarely replied "I don't know."

Freud's notion that people actively try to forget unwanted past experiences has been confirmed by fMRI research (Anderson et al. 2004). The process involves a novel form of reciprocal interaction between the prefrontal cortex and the hippocampus (see Figure 1–1). When subjects control unwanted memories, there is increased dorsolateral prefrontal activation associated with reduced hippocampal activation. The magnitude of forgetting is predicted by prefrontal, cortical, and right hippocampal activations.

Psychic Determinism

To assert that symptoms and behavior are external manifestations of unconscious processes is to touch on a third principle of dynamic psychiatry—psychic determinism. The psychodynamic approach asserts that we are consciously confused and unconsciously controlled. We go through our daily lives as though we have freedom of choice, but we are actually far more restricted than we think. To a large extent, we are characters living out a script written by the unconscious. Our choices of marital partners, our vocational interests, and even our leisure-time pursuits are not randomly selected; they are shaped by unconscious forces that are in dynamic relationship with one another.

By way of example, one young woman learned in the course of her psychotherapy that her choice of medicine as a career was profoundly shaped by events in her childhood and her reactions to them. When she was 8 years old, her mother succumbed to cancer. The little girl witnessing this tragedy felt helpless and powerless at the time, and her decision to be a physician was partly determined by an unconscious wish to gain mastery and control over disease and death. At an unconscious level, being a physician was an attempt to actively master a passively experienced trauma. On a conscious level, she simply experienced medicine as a fascinating and compelling field.

When human behavior becomes markedly symptomatic, the limits of free will become more obvious. A man who can only reach orgasm during masturbation by imagining humiliation at the hands of a muscle-bound sadist has lost the freedom to choose his sexual fantasies. The dynamic psychiatrist approaches these symptoms with the understanding that they represent adaptations to the demands of an unconscious script forged by a mixture of biological forces, early attachment problems, defenses, object relations, and disturbances in the self. In short, behavior has meaning.

The meaning is rarely as simple and straightforward as the foregoing example involving the physician. More commonly, a single behavior or symptom serves several functions and solves many problems. As Sherwood (1969)

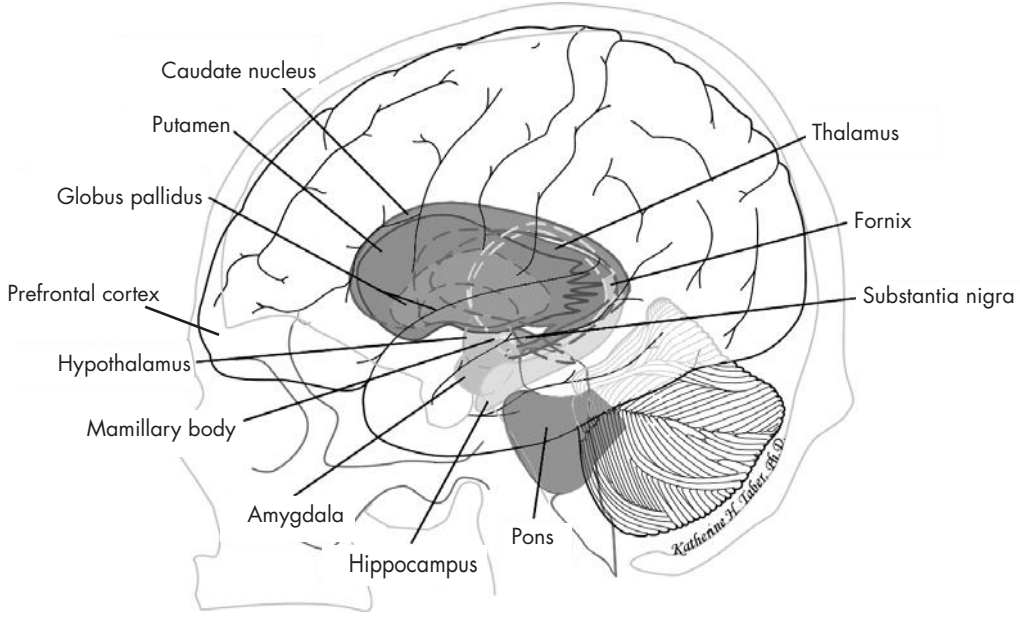

FIGURE 1–1. Schematic (lateral sagittal view) illustrating the relative positions of the prefrontal cortex and the hippocampus.
Source. Reprinted from Hurley RA, Hayman LA, Taber KH: "Clinical Imaging in Neuropsychiatry," in *The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Sciences,* 4th Edition. Edited by Yudofsky SC, Hales RE. Washington, DC, American Psychiatric Publishing, 2002, pp. 245–283. Copyright 2002, American Psychiatric Publishing. Used with permission.

pointed out, "Freud clearly held that the causes of behavior were *both* complex (overdetermined) and multiple (in the sense of their being alternate sets of sufficient conditions)" (p. 181). In other words, certain behaviors or symptoms are at times caused by a specific intrapsychic constellation of factors, but in other instances they are produced by a multitude of other etiological forces. It is sufficient to say that the psychodynamic view of human behavior defines it as the end result of many different conflicting forces that serve a variety of different functions corresponding both to the demands of reality and to unconscious needs.

The principle of psychic determinism, although certainly a bedrock notion, calls for two caveats. First, unconscious factors do not determine all behaviors or symptoms. When a patient with Alzheimer's disease forgets the name of his spouse, it probably is not a parapraxis. When a patient with partial complex seizures ritualistically buttons and unbuttons his shirt during the aura of his seizure, the symptom can likely be attributed to an irritable focus of the temporal lobe. The dynamic psychiatrist's task is to sort out which symptoms and behaviors can or cannot be explained by dynamic factors. The second caveat derives from experience with patients who make no effort to change their behavior because they claim to be passive victims of unconscious forces. Within the concept of psychic determinism, there is room for choice. Although it may be more restricted than we like to think, conscious intention to change can be an influential factor in recovery from symptoms (Appelbaum 1981). The dynamic psychiatrist must be wary of the patient who justifies remaining ill by invoking psychic determinism.

Past Is Prologue

A fourth basic principle of dynamic psychiatry is that the experiences of infancy and childhood are crucial determinants of the adult personality. In the succinct words of William Wordsworth, "The child is father of the man." The dynamic psychiatrist listens intently when a patient speaks of childhood memories, knowing that these experiences may play a critical role in the current presenting problems. Indeed, etiology and pathogenesis are often linked to childhood events in the dynamic view. In some cases, overt trauma, such as incest or physical abuse, leads to disturbances in the adult personality. More often, the chronic, repetitive patterns of interaction within a family are of greater etiological significance.

The dynamic point of view also takes into consideration the fact that infants and children perceive their environment through highly subjective filters that may distort the real qualities of the figures around them. Similarly, certain children are constitutionally difficult to raise no matter how effective

their parents may be. Research has long revealed several discrete constitutional temperaments in newborn infants (Thomas and Chess 1984). The etiology of some psychiatric illness may be related to how good the "fit" is between the temperament of the child and the temperament of the parenting figure. The hyperirritable child who does reasonably well with a calm and low-key mother may do poorly with a high-strung mother. This model of "goodness of fit" avoids blaming either parents or children for the latter's psychiatric problems.

Theories of childhood development have always been central to dynamic psychiatry. Freud postulated that a child passes through three principal psychosexual stages on the road to maturity. Each of these—the oral, the anal, and the genital—is associated with a particular bodily zone where Freud believed that the libido, or sexual energy, of the child was concentrated. As a result of environmental trauma, constitutional factors, or both, a child may become developmentally arrested at the oral or anal phase, resulting in a fixation that is retained into adult life. Under stress, the adult may regress to this more primitive phase of development and manifest the mental organization of the instinctual gratification associated with that phase. Although Freud reconstructed childhood development retrospectively based on the reports of adult patients in psychoanalysis, subsequent psychoanalytic investigators have studied development prospectively through direct infant and child observation. These theories are discussed in more detail in Chapter 2.

The developmental perspective of psychodynamic thinking has recently been challenged by a wave of genetic reductionism. The decoding of the human genome has been a major breakthrough in science, but there has been a disconcerting trend to view the genome as synonymous with humanness. The bioethicist Alex Mauron (2001) stressed that personal identity does not overlap with genomic identity. Monozygotic twins with identical genomes can be highly distinct individuals. Fortunately, this reductionistic trend has resulted in a backlash from major scientists who have stressed that genes are in constant interplay with the environment and that DNA is not destiny. As Robinson (2004) notes, "We can now study genes in enough detail to move beyond the nature–nurture debate. It is now clear that DNA is both inherited and environmentally responsive" (p. 397). Paradoxically, contemporary genetic research and the study of brain plasticity have shown that genes are highly regulated by environmental signals throughout life (Hyman 1999). An individual's genetic endowment influences the type of parenting he or she receives, and this developmental input from parents and other figures in the environment may, in turn, influence the further readout of the genome. Neural connections between the cortex, limbic system, and autonomic nervous system become linked into circuits in accordance with specific experiences

of the developing organism. Hence, emotion and memory circuits are linked together because of consistent patterns of connection resulting from stimuli and the environment. This developmental pattern is often summarized as follows: "Neurons that fire together, wire together" (Schatz 1992, p. 64).

Primate research has been particularly useful in demonstrating how environmental influences may override genetic tendencies. Suomi (1991) noted that about 20% of infants in his monkey colony who were reared by their mothers reacted to brief separations with increased cortisol and adrenocorticotropic hormone levels, depressive reactions, and exaggerated norepinephrine turnover. This vulnerability appeared to be genetic. However, when unusually nurturing mothers within the monkey colony were placed with these infants, the inborn vulnerability to separation anxiety disappeared. These monkeys ultimately rose to the top of the social hierarchy in the monkey colony, suggesting that these "supermothers" helped the young monkeys to develop their innate sensitivity in an adaptive direction that allowed them to be more attuned to social cues and to respond to those cues in a way that was advantageous to them.

Five to 10 percent of field populations of rhesus monkeys are unusually impulsive, insensitive, and overtly aggressive in their interactions with other troop members (Suomi 2003). Rhesus monkeys, who share approximately 95% of their genes with human beings, also show commonalities in the linkage between impulsive aggression and measures of serotonergic metabolism (Higley et al. 1991). An inverse relationship exists between measures of cerebrospinal fluid (CSF) 5-hydroxyindoleacetic acid (5-HIAA) concentrations and measures of impulsive aggression. However, the inherited propensity to develop patterns of impulsive aggressiveness can be modified substantially by early experiences involving social attachment relationships. Monkeys reared by peers consistently demonstrate lower CSF concentrations of 5-HIAA compared with those reared by mothers.

The serotonin transporter gene (*5HTT*) has length variation in its promoter region that results in allelic variation in *5HTT* expression. A "short" allele (*LS*) confers low transcriptional efficiency to the 5*HTT* promoter relative to the "long" allele (*LL*), suggesting that low *5HTT* expression may result in decreased serotonergic function. Bennett et al. (2002) found that CSF 5-HIAA concentrations did not differ as a function of *5HTT* status for mother-reared subjects, whereas among peer-reared monkeys, individuals with the *LS* allele had significantly lower CSF 5-HIAA concentrations than those with the *LL* allele. Being reared by one's mother appeared to buffer any potential deleterious effects of the *LS* allele on serotonin metabolism. Conversely, peer-reared monkeys with the *LS* polymorphism exhibited much higher levels of impulsive aggression than their peer-reared counterparts with the *LL* polymorphism, who exhibited low levels similar to those of both

LL and *LS* mother-reared monkeys, again suggesting a buffering effect of maternal rearing.

Rhesus monkeys with low CSF concentrations of 5-HIAA are also prone to consume more alcohol in a "happy hour" situation in which 7% ethanol aspartame-flavored beverage is available (Suomi 2003). Here the data on maternal buffering effects strikingly reflect the role of environment on the influence of genes. Peer-reared monkeys with the *LS* allele consumed more alcohol than peer-reared monkeys with the *LL* allele. Exactly the reverse was true if the subjects were reared by mothers. The *LS* allele actually resulted in less alcohol consumption than the *LL* allele. Investigators concluded that the short allele of the *5HTT* gene may well lead to psychopathology among rhesus monkeys who have adverse early rearing histories but could possibly be *adaptive* for those monkeys who have secure early attachment relationships with their mothers (Suomi 2003).

In a series of studies, Meaney and his colleagues (Francis et al. 1999; Weaver et al. 2002, 2004) demonstrated that rat mothers who show increased care of their pups by grooming and licking them during nursing provide them with a lifelong protection from stress. The expression of genes regulating glucocorticoid receptors is enhanced as a result of this licking and grooming behavior. In concert with this enhanced expression is a suppression of genes regulating corticotropin-releasing factor synthesis. Even more striking is the fact that female pups of rat mothers who are high in licking and grooming behaviors become high licking and grooming mothers themselves. If female rat pups born to mothers low in grooming and licking behavior are raised by high licking and grooming mothers, they too become high licking and grooming mothers. This maternal behavior is transmitted across generations without altering the genome. Hence, this transmission is often referred to as *epigenetic* modifying or programming and is related to differences in DNA methylation (Weaver et al. 2004). Epigenetics describes the way our bodies can actually modify their genetic makeup.

Much of this research on the interplay between genes and environment in animals is finding counterparts in human subjects. The animal data suggest that there are windows in time during which a gene is dependent upon a certain type of environmental influence to determine its expression. Investigators have found similar windows in human development for periods of major structural change in brain formation (Ornitz 1991; Perry et al. 1995; Pynoos et al. 1997). Bremner et al. (1997), for example, have shown that adults with posttraumatic stress disorder who experienced childhood physical and sexual abuse had reduced left hippocampal volumes compared with matched control subjects. It may well be that traumatic experiences during stable periods of brain development can produce a form of regression to an earlier stage in neural function and structure (Pynoos et al. 1997).

As discussed in Chapter 17, Reiss et al. (1995) demonstrated that parental responses to children may affect the phenotypic expression of genetic vulnerability to antisocial behavior. Similarly, the trait of shyness, and possibly social phobia, appear to require environmental influences on the inherited vulnerability to that trait (Kagan et al. 1988). This phenomenon is discussed more thoroughly in Chapter 9.

The investigation of these serotonin transporter genes in rhesus monkeys has its parallel in human studies. A polymorphism in the promoter region of the serotonin transporter gene (5-*HTTLPR*) has been shown to affect the transcription rate of the gene, with the short (s) allele transcriptionally less efficient than the alternate long (l) allele. One meta-analysis (Karg et al. 2011) found strong evidence that 5-*HTTLPR* moderates the relationship between depression and stress, with the s allele associated with an increased risk of developing depression under stress. Another investigation (Xie et al. 2009) studied the interactions of stressful life events and the serotonin transporter 5-*HTTLPR* genotype on posttraumatic stress disorder diagnosis. These investigators found that although the 5-*HTTLPR* genotype alone did not predict the onset of PTSD, it interacted with adult traumatic events and childhood adversity to increase the risk for PTSD. Other studies using meta-analyses have resulted in negative results, and some commentators feel that there is little purpose in focusing on single variants because the impact of a broader network of genetic variations and environmental influences is necessary to come up with meaningful results (Blakely and Veenstra-VanderWeele 2011; Brzustowicz and Freedman 2011).

Transference

The persistence of childhood patterns of mental organization in adult life implies that the past is repeating itself in the present. Perhaps the most compelling example of this is the core psychodynamic concept of *transference,* in which the patient experiences the doctor as a significant figure from the patient's past. Qualities of that past figure will be attributed to the doctor, and feelings associated with that figure will be experienced in the same way with the doctor. The patient unconsciously *reenacts* the past relationship instead of remembering it and in so doing introduces to the treatment a wealth of information about past relationships.

Although the concept of transference is generally associated with psychoanalysis or psychotherapy, the therapeutic relationship is merely one example of a more general phenomenon. As Brenner (1982) put it: "*Every* object relation is a new addition of the first, definitive attachments of childhood.... Transference is ubiquitous, it develops in every psychoanalytic situation because it develops in every situation where another person is important

in one's life" (pp. 194–195). More recent contributions to the understanding of transference acknowledge that the clinician's *real* characteristics always contribute to the nature of the transference (Hoffman 1998; Renik 1993). In other words, if a therapist is silent and detached from the patient, a transference may develop to that therapist as cold, remote, and disengaged. Although the transference may stem in part from early attachments of childhood, it is also influenced by the therapist's actual behavior. Hence, every relationship in the clinical setting is a mixture of a real relationship and transference phenomena.

Some psychoanalysts argue that there are two dimensions of transference: 1) a repetitive dimension, in which the patient fears and expects the analyst to behave as the parents did, and 2) a selfobject dimension, in which the patient longs for a healing or corrective experience that was missing in childhood (Stolorow 1995). These aspects of transference oscillate between the foreground and the background of the patient's experience.

The dynamic psychiatrist recognizes the pervasiveness of transference phenomena and realizes that the relationship problems about which the patient complains will often manifest themselves in the patient's relationship with the treater. What is unique about the doctor–patient relationship in dynamic psychiatry is *not* the presence of transference, but the fact that it represents therapeutic material to be understood. When subjected to hateful invective from their patients, dynamic psychiatrists do not angrily reject them as most other people in their lives would. Instead, they attempt to determine what past relationship of the patient is being repeated in the present and what contribution their real characteristics may be making to the situation. In this sense, dynamic psychiatrists are defined as much by what they do *not* do as by what they do.

From a neuroscience perspective, we understand transference as related to internal representations of objects triggered by real characteristics of the therapist (Westen and Gabbard 2002). Representations exist as a network of neurons that can be activated in tandem. Thus representations are like potentials waiting to be activated when aspects of a therapist remind the patient of qualities similar to the figure represented in the patient's neural networks. A young man seeing an older male therapist with a beard may be reminded of his bearded father and begin to relate to the therapist as though he is his father. From a neuroscience perspective, the role of expectation involved in transference is analogous to how we deal with the blind spot where the optic nerve exits the eye (Solms and Turnbull 2003). Despite the "hole" in the visual field, we fill in the gap based on what we expect to see. The right orbitofrontal cortex is thought to play a key role in developing internal representations of self and other linked by affect states (Schore 1997). In this area of the brain, there is a convergence of subcortically processed informa-

tion about motivational and emotional states with cortically processed information concerning the external environment. Hence the networks that generate representations receive a good deal of the encoding information from this portion of the brain (see Figure 1–2).

Schore (2011) stresses that the implicit self is forged in the developing right brain. Whereas the left hemisphere mediates most linguistic behaviors, the right hemisphere is responsible for intuition and the relational aspects of the unconscious. Thus, in psychotherapy the patient's right hemisphere is involved with tuning in to the mental state of the therapist as well as to one's own mental state. What follows from this understanding is that there is an implicit transference formed that is based largely on nonverbal communication between the two members of the psychotherapy dyad. Often the "gut feelings" or intuitions are not simply random guesses but conclusions made unconsciously on the basis of the implicit communication between therapist and patient.

Countertransference

An overarching principle embraced by those of us who practice dynamic psychiatry is that we are basically more similar to our patients than we are different from them. The psychological mechanisms in pathological states are merely extensions of principles involved in normal developmental functioning. Doctor and patient are both human beings. Just as patients have transference, treaters have countertransference. Because every current relationship is a new addition of old relationships, it follows logically that countertransference in the psychiatrist and transference in the patient are essentially identical processes—each unconsciously experiences the other as someone from the past.

The concept of *countertransference* has undergone considerable evolution since its inception (Hamilton 1988; Kernberg 1965). Freud's (1912/1958) narrow definition referred to the analyst's transference to the patient or the analyst's response to the patient's transference. Implicit in this conceptualization is the emergence of unresolved conflicts from the analyst's unconscious. Winnicott (1949), however, in working with psychotic patients and those with severe personality disorders, noted a different form of countertransference. He termed the feeling *objective hate,* because it was not a reaction stemming from unresolved unconscious conflicts in the treater but rather a natural reaction to the patient's outrageous behavior. It is objective in the sense that virtually everyone would react similarly to a patient's provocative behavior.

This broader definition of countertransference as the therapist's conscious and appropriate total emotional reaction to the patient is gaining

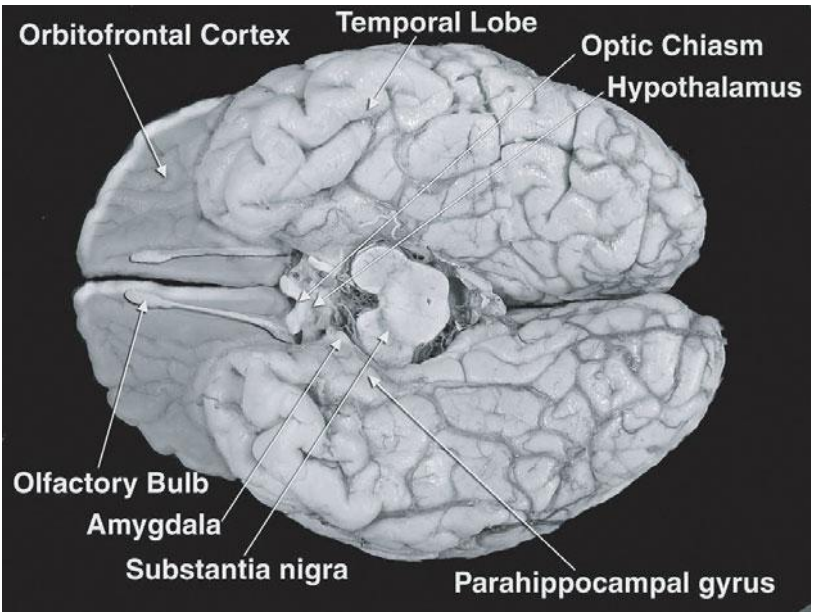

FIGURE 1–2. Orbitofrontal cortex on inferior surface of brain.

greater acceptance, particularly because it helps characterize the work with patients with severe personality disorders, which are an increasingly common segment of the dynamic psychiatrist's practice. This definition serves to attenuate the pejorative connotation of countertransference—unresolved problems in the treater that require treatment—and to replace it with a conceptualization that views countertransference as a major diagnostic and therapeutic tool that tells the treater a good deal about the patient's internal world.

As the definition has continued to evolve, countertransference is now generally regarded as involving *both* the narrow and the totalistic, or broad, characteristics. Most theoretical perspectives view countertransference as entailing a jointly created reaction in the clinician that stems in part from contributions of the clinician's past and in part from feelings *induced* by the patient's behavior (Gabbard 1995). In some cases the emphasis may be more on the contributions of the clinician than on those of the patient; in other cases the reverse may be true. Countertransference is both a source of valuable information about the patient's internal world and an interference with the treatment.

Resistance

The last major principle of dynamic psychiatry involves the patient's wish to preserve the status quo, to oppose the treater's efforts to produce insight and change. In his early papers on technique, Freud (1912/1958) had already noted these powerful oppositional forces: "The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones" (p. 103). Resistances to treatment are as ubiquitous as transference phenomena and may take many forms, including being late to appointments, refusing to take medications, forgetting the psychiatrist's advice or interpretations, being silent in therapy sessions, focusing on unimportant material during the sessions, or forgetting to pay the therapy bill, to name only a few. Resistance may be conscious, preconscious, or unconscious. All resistance has in common an attempt to avoid unpleasant feelings, whether anger, guilt, hate, love (if directed toward a forbidden object such as the therapist), envy, shame, grief, anxiety, or some combination of these.

Resistance defends the patient's illness. The patient's characteristic defense mechanisms designed to safeguard against unpleasant affects come to the fore during dynamic treatment. In fact, resistance may be defined as the patient's defenses as they manifest themselves in psychodynamic treatment (Greenson 1967). The difference between resistances and defense mechanisms is simply that the former can be observed, whereas the latter must be inferred (Thomä and Kächele 1987). The strength of the defense or resistance is necessarily proportional to the strength of the underlying impulse. As Ralph Waldo Emerson once observed, "The louder he talked of his honor, the faster we counted our spoons."

The dynamic psychiatrist expects to encounter resistance to treatment and is prepared to address this phenomenon as part and parcel of the treatment process. Whereas other treaters may get angry when their patients do not comply with prescribed treatments, dynamic psychiatrists are curious to know what this resistance is protecting and what past situation is being reenacted. Despite the connotation of resistance as an obstacle that must be removed to conduct the treatment, to a large extent, understanding the resistance *is* the treatment in many cases. Freud tended to use resistance to mean two different phenomena: 1) a stoppage of the patient's free associations and 2) a revelation of a highly significant internal object relationship from the patient's past transported into the present moment with the treater (Friedman 1991). The manner in which the patient resists is likely to be a re-creation of a past relationship that influences a variety of present-day re-

lationships. For example, patients who spent their childhoods rebelling against their parents may unconsciously find themselves rebelling against their doctor as well as other authority figures. The dynamic clinician helps the patient understand these patterns so that they become fully conscious.

Neurobiology and Psychotherapy

Psychodynamic psychotherapy is a critical part of the psychodynamic psychiatrist's identity. The findings from neurobiology are informing our understanding of psychotherapy in recent years. A brief overview of these findings underscores the fact that psychotherapy has a major impact on the brain and cannot be dismissed as mere "handholding" or benign reassurance.

In a series of innovative experiments with the marine snail *Aplysia,* Kandel demonstrated how synaptic connections can be permanently altered and strengthened through the regulation of gene expression connected with learning from the environment (Kandel 1979, 1983, 1998). In this organism, the number of synapses doubles or triples as a result of learning. Kandel postulated that psychotherapy may bring about similar changes in brain synapses. In the same way that the psychotherapist conceptualizes representations of self and objects as malleable through psychotherapeutic intervention, Kandel noted that the brain itself is a plastic and dynamic structure. If psychotherapy is regarded as a form of learning, then the learning process that occurs in psychotherapy may produce alterations of gene expression and thereby alter the strength of synaptic connections. The sequence of a gene—the template function—cannot be affected by environmental experience, but the transcriptional function of the gene—the ability of a gene to direct the manufacture of specific proteins—is certainly responsive to environmental factors and regulated by those influences.

An integral part of psychodynamic psychotherapy is the acquisition of insight about one's problems. Until recently, the process of gaining insight remained mysterious in terms of its neural correlates. Jung-Beeman et al. (2004) have shed some light on this process. Using fMRI data and scalp electroencephalogram recordings, they identified distinct patterns that suggest differential hemispheric involvement for insight and non-insight solutions. Subjects solved verbal problems and after each correct solution indicated whether they solved the problem with or without insight. The investigators found two major neural correlates of insight. Imaging demonstrated increased activity in the right hemisphere anterior superior temporal gyrus for insight relative to non-insight solutions. Scalp electroencephalogram recordings revealed a sudden burst of high-frequency (gamma band) neural activity in the same area, beginning 0.3 seconds prior to insight solutions.

Hence the sudden flash of insight phenomenon in therapy may be reflected in specific neural activity that occurs when connections that were previously elusive become apparent.

Researchers in Finland showed that psychodynamic therapy may have a significant impact on serotonin metabolism (Karlsson et al. 2010). These investigators randomly assigned 23 patients with major depressive disorder to either short-term dynamic psychotherapy or fluoxetine for a total of 16 weeks. Using positron emission tomography (PET) scans, the researchers estimated 5-HT_{1A} receptor density before and after treatment. They found that psychotherapy increased the binding to 5-HT_{1A} receptors, but antidepressant medication did not alter the 5-HT_{1A} receptor density in these patients. They concluded that psychotherapy leads to changes in the molecular structure of the synapse in patients with major depressive disorder. In a subsequent analysis of the findings, the investigators showed that the increase in the density of the 5-HT_{1A} receptors was strongly associated with an increase in social and occupational functioning (Karlsson et al. 2013).

The combination of psychotherapy and pharmacotherapy is increasingly common in psychiatry as the evidence accumulates that many conditions respond better to combined treatment than to either modality alone (Gabbard and Kay 2001). Because both treatments affect the brain, in a very real sense, they are both biological treatments. However, the mechanisms of action of the two treatments may occur in very different areas of the brain. Goldapple et al. (2004), using PET, scanned 17 unmedicated patients with unipolar depression before and after a 15- to 20-session course of cognitive-behavioral therapy. They compared the findings to a separate group of 13 depressed patients who responded to paroxetine. The psychotherapy appeared to alter brain regions that medications did not touch. The psychotherapy was associated with increases in metabolic activity in the anterior cingulate and the hippocampus, with decreases in metabolic activity in the dorsal, ventral, and medial frontal cortices. By contrast, paroxetine showed increases in metabolic activity in the prefrontal cortex and decreases in the brain stem and subgenual cingulate. In brief, therapy seemed to work in a "top down" manner, whereas medication worked "bottom up."

Most of the research regarding neurobiological mechanisms in psychotherapy has been conducted on relatively brief therapies. However, Buchheim et al.(2012) investigated recurrently depressed unmedicated outpatients and control participants matched for sex, age, and education before and after 15 months of psychodynamic psychotherapy. The participants were scanned at two time points, during which presentations of attachment-related scenes with neutral descriptions were alternated with descriptions containing personal core sentences previously extracted from an attachment interview. The outcome measure was the interaction of the signal difference

between personal and neutral presentations with group and time and its association with symptom improvement during therapy. The signals associated with processing personalized attachment material varied in patients from baseline to endpoint, but there was no such variation in the control patients. The depressed subjects showed a higher activation in the left anterior hippocampus/amygdala, subgenual cingulate, and medial prefrontal cortex before treatment and a reduction in these areas after 15 months. This reduction was linked to improvement in depression specifically and in the medial prefrontal cortex with symptom improvement more generally.

This brief survey of recent neurobiological research relevant to psychotherapy brings us back to the mind–brain dilemmas discussed earlier in the chapter. Knowledge of brain areas activated by emotions in the presence of symptoms generated by biological forces in no way diminishes the importance of individual meanings and idiosyncratic interpretations of events in one's life based on previous experiences. In psychodynamic psychiatry, we must differentiate causation from meaning. Psychiatry that loses the domain of meaning is mindless. Preexisting psychodynamic conflicts may attach themselves to biologically driven symptoms, with the result that the symptoms then function as a vehicle for the expression of the conflicts (Gabbard 1992). Consider an analogy: when a magnet is placed under a sheet of paper containing iron filings, the filings line up in formation and follow the movement of the magnet along the surface of the paper. Similarly, psychodynamic issues frequently appropriate the magnet-like biological forces for their own purposes. Auditory hallucinations are generated in part by alterations in neurotransmitters in persons with schizophrenia, but the content of hallucinations often has specific meanings based on the patient's psychodynamic conflicts.

Role of the Dynamic Psychiatrist in Contemporary Psychiatry

Training in dynamic psychiatry significantly broadens the scope of the clinician's expertise. One real advantage of the dynamic approach is its attention to the role of personality factors in illness. In fact, personality and its influence on the patient is a principal area of expertise for dynamic psychiatrists (Michels 1988). As Perry et al. (1987) persuasively argued, because every treatment involves therapeutic management and modification of the patient's personality, a psychodynamic evaluation is applicable to all patients, not simply those referred for long-term psychoanalytic psychotherapy. Characterological resistances to treatment frequently torpedo any well-designed treatment plan. Symptoms are embedded in character structure, and the dynamic psychiatrist recognizes that in many cases one cannot treat the symptoms without first addressing the character structure.

Failure to comply with pharmacotherapeutic regimens often can be understood along conventional lines of transference, countertransference, and resistance issues. A considerable literature has accrued on the practice of dynamic pharmacotherapy (Appelbaum and Gutheil 1980; Book 1987; Docherty and Fiester 1985; Docherty et al. 1977; Gabbard and Kay 2001; Gutheil 1977, 1982; Karasu 1982; Kay 2001; Ostow 1983; Riba and Balon 2005; Thompson and Brodie 1981; Wylie and Wylie 1987), and there has been a broad consensus that psychodynamic meanings of medications may pose formidable obstacles to compliance with medication regimens. In Chapter 5, I consider dynamic approaches to pharmacotherapy in some detail.

A dynamic therapeutic approach is certainly not necessary for every psychiatric patient. Those who respond well to medications, electroconvulsive therapy, brief psychotherapies, or behavioral desensitization may not require the services of a dynamic psychiatrist. As with all other schools of psychiatry, the dynamic psychotherapeutic approach cannot effectively treat all psychiatric illnesses or patients.

A strictly dynamic therapeutic approach should probably be reserved for patients who most need it and who will not respond to any other interventions. However, a *dynamically informed* approach to most—if not all—patients will enrich the psychiatrist's practice and enhance the clinician's sense of mastery over the mysteries of the human psyche. It will also help the dynamic psychiatrist identify and understand the daily countertransference problems that interfere with effective diagnosis and treatment. The principal advantage of the psychodynamic perspective is that it operationalizes the time-honored axiom that the "person" is the main target of any effective psychiatric intervention. As Hippocrates said long ago, "It is more important to know the person with the illness than the illness the person has."

References

Anderson MC, Ochsner KN, Kuhl B, et al: Neural systems underlying the suppression of unwanted memories. Science 303:232–235, 2004

Andreasen NC: Linking mind and brain in the study of mental illness: a project for a scientific psychopathology. Science 275:1586–1593, 1997

Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340–346, 1980

Appelbaum SA: Effecting Change in Psychotherapy. New York, Jason Aronson, 1981

Banaji MR, Greenwald AG: Blindspot: Hidden Biases of Good People. New York, Delacorte, 2013

Bechara A, Tranel D, Damasio H, et al: Double association of conditioning and declarative knowledge relative to the amygdala and hippocampus in humans. Science 269:1115–1118, 1995

Bennett AJ, Lesch KP, Heils A, et al: Early experience and serotonin transporter gene variation interact to influence primate CNS function. Mol Psychiatry 7:118–122, 2002

Blakely RD, Veenstra-VanderWeele J: Genetic indeterminism, the 5-HTTLPR, and the paths forward in neuropsychiatric genetics. Arch Gen Psychiatry 68:457–458, 2011

Book HE: Some psychodynamics of non-compliance. Can J Psychiatry 32:115–117, 1987

Bremner JD, Randall P, Vermetten E, et al: Magnetic resonance imaging–based measurement of hippocampal volume in posttraumatic stress disorder related to childhood physical and sexual abuse: a preliminary report. Biol Psychiatry 41: 23–32, 1997

Brenner C: The Mind in Conflict. New York, International Universities Press, 1982

Brzustowicz L, Freedman R: Digging more deeply for genetic effects in psychiatric illness. Am J Psychiatry 168:1017–1020, 2011

Buchheim A, Viviani R, Kessler H, et al: Changes in prefrontal-limbic function in major depression after 15 months of long-term psychotherapy. PLoS One 7: e33745. doi: 10.1371/journal.pone.003745.g003, 2012

Cloninger CR: The Silence of Well-Being: Biopsychosocial Foundations. Oxford, UK, Oxford University Press, 2004

Damasio A: Looking for Spinoza: Joy, Sorrow and the Feeling Brain. New York, Harcourt, 2003

Docherty JP, Fiester SJ: The therapeutic alliance and compliance with psychopharmacology, in Psychiatry Update: American Psychiatric Association Annual Review, Vol 4. Edited by Hales RE, Frances AJ. Washington, DC, American Psychiatric Press, 1985, pp 607–632

Docherty JP, Marder SR, Van Kammen DP, et al: Psychotherapy and pharmacotherapy: conceptual issues. Am J Psychiatry 134:529–533, 1977

Dumit J: Picturing Personhood: Brain Scans and Biomedical Identity. Princeton, NJ, Princeton University Press, 2004

Edelson M: Psychoanalysis: A Theory in Crisis. Chicago, IL, University of Chicago Press, 1988

Ellenberger HF: The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry. New York, Basic Books, 1970

Francis D, Diorio J, Liu D, et al: Non-genomic transmission across generations of maternal behavior and stress responses in the rat. Science 286:1155–1158, 1999

Freud S: The interpretation of dreams (1900), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vols 4, 5. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 1–627

Freud S: The psychopathology of everyday life (1901), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 6. Translated and edited by Strachey J. London, Hogarth Press, 1960, pp 1–279

Freud S: The dynamics of transference (1912), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 97–108

Freud S: The unconscious (1915), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 159–215

Friedman L: A reading of Freud's papers on technique. Psychoanal Q 60:564–595, 1991

Gabbard GO: Psychodynamic psychiatry in the "decade of the brain." Am J Psychiatry 149:991–998, 1992

Gabbard GO: Countertransference: the emerging common ground. Int J Psychoanal 76:475–485, 1995

Gabbard GO: A neurobiologically informed perspective on psychotherapy. Br J Psychiatry 177:117–122, 2000

Gabbard GO: Mind, brain, and personality disorders. Am J Psychiatry 162:648–655, 2005

Gabbard GO, Kay J: The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? Am J Psychiatry 158:1956–1963, 2001

Galdi S, Arcuri L, Gawronski B: Automatic mental associations predict future choices of undecided decision-makers. Science 321:1100–1102, 2008

Goldapple K, Segal E, Garson C, et al: Modulation of cortical-limbic pathways in major depression: treatment-specific effects of cognitive behavior therapy. Arch Gen Psychiatry 61:34–41, 2004

Greenson RR: The Technique and Practice of Psychoanalysis. New York, International Universities Press, 1967

Gutheil TG: Psychodynamics in drug prescribing. Drug Ther 2:35–40, 1977

Gutheil TG: The psychology of psychopharmacology. Bull Menninger Clin 46:321–330, 1982

Hamilton NG: Self and Others: Object Relations Theory in Practice. Northvale, NJ, Jason Aronson, 1988

Heim CM, Mayberg HS, Mletzko T, et al: Decreased cortical representation of genital somatosensory field after childhood sexual abuse. Am J Psychiatry 170:616–623, 2013

Higley JD, Suomi S, Linnoila M: CSF monoamine metabolite concentrations vary according to age, rearing and sex, and are influenced by the stressor of social separation in rhesus monkeys. Psychopharmacology (Berl) 103:551–556, 1991

Hoffman IZ: Ritual and Spontaneity in the Psychoanalytic Process: A Dialectical-Constructivist View. Hillsdale, NJ, Analytic Press, 1998

Horwitz RI, Cullen MR, Abell J, et al: Medicine. (De)personalized medicine. Science 339:1155–1156, 2013

Hyman SE: Looking to the future: the role of genetics and molecular biology in research on mental illness, in Psychiatry in the New Millennium. Edited by Weissman S, Sabshin M, Eist H. Washington, DC, American Psychiatric Press, 1999, pp 101–122

Jen G: Art, Culture, and the Interdependent Self. Cambridge, MA, Harvard University Press, 2013

Jung-Beeman M, Bowden EM, Haberman, et al: Neural activity when people solve verbal problems with insight. PLoS Biol 2:500–510, 2004

Kagan J, Reznick JS, Snidman N: Biological bases of childhood shyness. Science 240: 167–171, 1988

Kandel ER: Psychotherapy and the single synapse: the impact of psychiatric thought on neurobiologic research. N Engl J Med 301:1028–1037, 1979

Kandel ER: From metapsychology to molecular biology: explorations into the nature of anxiety. Am J Psychiatry 140:1277–1293, 1983

Kandel ER: A new intellectual framework for psychiatry. Am J Psychiatry 155:457–469, 1998

Karasu TB: Psychotherapy and pharmacotherapy: toward an integrative model. Am J Psychiatry 139:1102–1113, 1982

Karg K, Burmeister M, Shedden K, et al: The serotonin transporter promoter variant (5-HTTLPR), stress, and depression meta-analysis revisited. Arch Gen Psychiatry 68:444–454, 2011

Karlsson H, Hirvonen J, Kajander J, et al: Psychotherapy increases brain serotonin 5-HT1A receptors in patients with major depressive disorder. Psychol Med 40: 523–528, 2010

Karlsson H, Hirvonen J, Salminen J, et al: Increased serotonin receptor 1A binding in major depressive disorder after psychotherapy, but not after SSRI pharmacotherapy, is related to improved social functioning capacity. Psychother Psychosom 82:260–261, 2013

Kay J (ed): Integrated Treatment of Psychiatric Disorders (Review of Psychiatry Series, Vol 20, No 2; Oldham JM, Riba MB, Series Editors). Washington, DC, American Psychiatric Press, 2001

Keller EF: The Mirage of a Space Between Nature and Nurture. Durham, NC, Duke University Press, 2011

Kendler KS: A psychiatric dialogue on the mind-body problem. Am J Psychiatry 158: 989–1000, 2001

Kernberg OF: Notes on countertransference. J Am Psychoanal Assoc 13:38–56, 1965

LeDoux J: Afterword. Psychoanal Rev 99:594–606, 2012

Mauron A: Is the genome the secular equivalent of the soul? Science 291:831–832, 2001

McGinn C: The Mysterious Flame: Conscious Minds in the Material World. New York, Basic Books, 1999

Michels R: The future of psychoanalysis. Psychoanal Q 57:167–185, 1988

Nemiah JC: Foundations of Psychopathology. New York, Oxford University Press, 1961, p 4

Ornitz EM: Developmental aspects of neurophysiology, in Child and Adolescent Psychiatry: A Comprehensive Textbook, 2nd Edition. Edited by Lewis M. Baltimore, MD, Williams & Wilkins, 1991, pp 39–51

Ostow M: Interactions of psychotherapy and pharmacotherapy (letter). Am J Psychiatry 140:370–371, 1983

Pally R: How brain development is shaped by genetic and environmental factors. Int J Psychoanal 78:587–593, 1997

Perry DB, Pollard RA, Blakeley TL, et al: Childhood trauma, the neurobiology of adaptation and "use-dependent" development of the brain: how "states" become "traits." Infant Ment Health J 16:271–291, 1995

Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 144:543–550, 1987

Pynoos RA, Steinberg AM, Ornitz EM, et al: Issues in the developmental neurobiology of traumatic stress. Ann NY Acad Sci 821:176–193, 1997

Reiss D, Hetherington EM, Plomin R, et al: Genetic questions for environmental studies: differential parenting and psychopathology in adolescence. Arch Gen Psychiatry 52:925–936, 1995

Renik O: Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. Psychoanal Q 62:553–571, 1993

Riba MB, Balon R: Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment (Core Competencies in Psychotherapy Series, Glen O. Gabbard, Series Editor). Washington, DC, American Psychiatric Publishing, 2005

Robinson GE: Genome mix: beyond nature and nurture. Science 304:397–399, 2004

Schatz CJ: The developing brain. Sci Am 267:60–67, 1992

Schore AN: A century after Freud's project: is a rapprochement between psychoanalysis and neurobiology at hand? J Am Psychoanal Assoc 45:807–840, 1997

Schore AN: The right brain implicit self lies at the core of psychoanalysis. Psychoanal Dialogues 21:75–100, 2011

Searle JR: The Rediscovery of the Mind. Cambridge, MA, MIT Press, 1992

Sherwood M: The Logic of Explanation in Psychoanalysis. New York, Academic Press, 1969

Shevrin H, Bond J, Brakel LA, et al: Conscious and Unconscious Processes: Psychodynamic, Cognitive, and Neurophysiological Convergences. New York, Guilford, 1996

Solms M, Turnbull O: The Brain and the Inner World: An Introduction to the Neuroscience of Subjective Experience. New York, Other Press, 2003

Squire LR: Memory and Brain. New York, Oxford University Press, 1987

Stolorow RD: An intersubjective view of self psychology. Psychoanalytic Dialogues 5:393–399, 1995

Suomi SJ: Early stress and adult emotional reactivity in rhesus monkeys, in Childhood Environment and Adult Disease (CIBA Foundation Symposium No. 156). Edited by Bock GR and CIBA Foundation Symposium Staff. Chichester, UK, Wiley, 1991, pp 171–188

Suomi SJ: Social and biological mechanisms underlying impulsive aggressiveness in rhesus monkeys, in The Causes of Conduct Disorder and Severe Juvenile Delinquency. Edited by Lahey BB, Moffitt T, Caspi A. New York, Guilford, 2003, pp 345–362

Thomä H, Kächele H: Psychoanalytic Practice, Vol 1: Principles. Translated by Wilson M, Roseveare D. New York, Springer-Verlag, 1987

Thomas A, Chess S: Genesis and evolution of behavioral disorders: from infancy to early adult life. Am J Psychiatry 141:1–9, 1984

Thompson EM, Brodie HKH: The psychodynamics of drug therapy. Curr Psychiatr Ther 20:239–251, 1981

Watson JB: Behaviorism (1924). New York, WW Norton, 1930

Weaver IC, Szyf M, Meaney MJ: From maternal care to gene expression: DNA methylation and the maternal programming of stress responses. Endocr Res 28:699, 2002

Weaver ICG, Cervoni N, Champagne FA, et al: Epigenetic programming by maternal behavior. Nat Neurosci 7:847–854, 2004

Weinberger J, Hardaway R: Separating science from myth in subliminal psychodynamic activation. Clin Psychol Rev 10:727–756, 1990

Westen D: Mind, Brain, and Culture, 2nd Edition. New York, Wiley, 1999a

Westen D: The scientific status of unconscious processes: is Freud really dead? J Am Psychoanal Assoc 47:1061–1106, 1999b

Westen D, Gabbard GO: Developments in cognitive neuroscience, II: implications for theories of transference. J Am Psychoanal Assoc 50:99–134, 2002

Winnicott DW: Hate in the counter-transference. Int J Psychoanal 30:69–74, 1949

Wylie HW Jr, Wylie ML: An effect of pharmacotherapy on the psychoanalytic process: case report of a modified analysis. Am J Psychiatry 144:489–492, 1987

Xie P, Kranzler HR, Poling J, et al: Interactive effect of stressful life events and the serotonin transporter 5-HTTLPR genotype on post-traumatic stress disorder diagnosis in two independent populations. Arch Gen Psychiatry 66:1201–1209, 2009

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CHAPTER 2

THE THEORETICAL BASIS OF DYNAMIC PSYCHIATRY

> Nothing is as practical as a good theory.
>
> *Kurt Lewin*

Like a sailor without a sextant, a psychiatrist who sets out to navigate the dark waters of the unconscious without a theory will soon be lost at sea. Psychoanalytic theory is the foundation of dynamic psychiatry. It brings order to the seemingly chaotic inner world of the patient. It allows the psychiatrist to supplement and transcend the descriptive level of cataloging symptoms and applying diagnostic labels. It provides a means of entering and understanding the cavernous interior of the mind. Theory not only guides clinicians toward diagnostic understanding, it also informs the choice of treatment for each patient. Theoretical understanding helps the dynamic psychiatrist decide what to say, when to say it, how to say it, and what is better left unsaid.

Contemporary dynamic psychiatry subsumes at least four broad psychoanalytic theoretical frameworks: 1) ego psychology, derived from the classic psychoanalytic theory of Freud; 2) object relations theory, derived from the work of Melanie Klein and members of the "British School," such as Fair-

bairn and Winnicott and also including American relational/intersubjectivist theories; 3) self psychology, originated by Heinz Kohut and elaborated by many subsequent contributors; and 4) attachment theory.

Although volumes have been written on each of these schools of thought, here we merely examine the salient features of the four theoretical frameworks. In subsequent chapters the theories are "fleshed out" to illustrate their application to clinical situations.

Ego Psychology

Freud's early years as a psychoanalytic investigator were heavily influenced by his topographic model (described in Chapter 1). Hysterical symptoms were seen as the result of repressed memories of events or ideas. Freud hypothesized that psychotherapeutic intervention could lift repression, leading to the recall of memories. In turn, a detailed verbal description of the remembered pathogenic idea or event, accompanied by intense affect, would lead to the symptom's disappearance. For example, a young man's paralyzed arm might be the result of a repressed wish to hit his father. According to this model, the young man might regain the use of his arm by retrieving the wish from his unconscious, verbalizing it, and expressing the anger toward his father. This cathartic method, also known as *abreaction*, makes conscious the unconscious pathogenic memory.

However, the topographic model soon began to fail Freud. He repeatedly encountered resistances in his patients to his therapeutic maneuvers. Some memories could not be brought back into consciousness. The defense mechanisms responsible for this resistance were themselves unconscious and therefore inaccessible. These observations led Freud to conclude that the ego has both conscious and unconscious components.

With the publication of "The Ego and the Id," Freud (1923/1961) introduced his tripartite structural theory of ego, id, and superego. In the structural model, which superseded the topographic model, the *ego* was viewed as distinct from the instinctual drives. The conscious aspect of the ego was the executive organ of the psyche, responsible for decision making and integration of perceptual data. The unconscious aspect of the ego contained defense mechanisms, such as repression, that were necessary to counteract the powerful instinctual drives harbored in the id—specifically, sexuality (libido) and aggression.

The *id* is a completely unconscious intrapsychic agency that is only interested in discharging tension. The id is controlled both by the unconscious aspects of the ego and by the third agency of the structural model—the superego. For the most part, the *superego* is unconscious, but aspects of it are

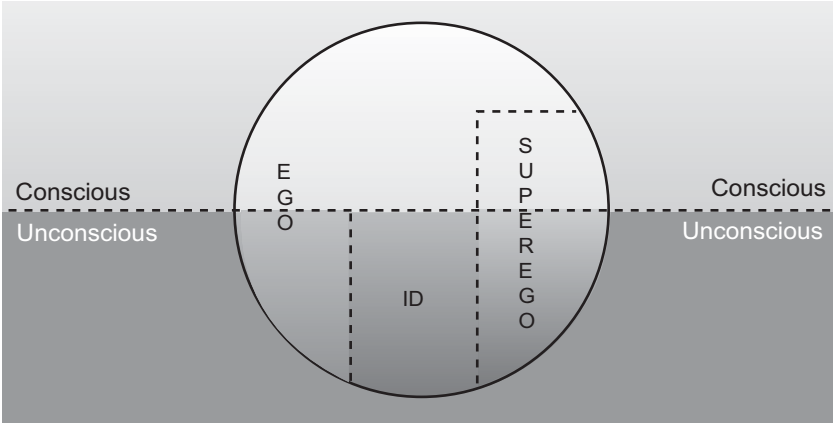

FIGURE 2–1. *The structural model.*
Note. The preconscious has been deleted for the sake of simplicity.

certainly conscious. This agency incorporates the moral conscience and the ego ideal. The former *proscribes* (i.e., dictates what one should *not* do based on the internalization of parental and societal values), whereas the latter *prescribes* (i.e., dictates what one ought to do or be). The superego tends to be more sensitive to the strivings of the id and is therefore more immersed in the unconscious than is the ego (Figure 2–1).

Ego psychology conceptualizes the intrapsychic world as one of interagency conflict. The superego, the ego, and the id battle among themselves as sexuality and aggression strive for expression and discharge. Conflict between the agencies produces anxiety. This signal anxiety (Freud 1926/1959) alerts the ego that a defense mechanism is required. The mechanism of neurotic symptom formation may be understood in this manner. Conflict produces anxiety, which results in defense, which leads to a compromise between the id and the ego. A symptom, then, is a compromise formation that both defends against the wish arising from the id and gratifies the wish in disguised form.

For example, an accountant with obsessive-compulsive personality disorder was always concerned that his boss might be angry with him. He secretly resented his boss, and his anxiety about his boss's anger was a projection of his own wish to explode at his boss and tell him what he thought of him. As an unconscious defense, he was obsequious and ingratiating toward his boss to make sure that he could not possibly be accused of being angry with him. The boss found this behavior irritating, and as a result there was an ever-present tension between the two of them. In other words, the accountant's obsequious style defended against the eruption of his own

anger, but it also contained an attenuated expression of his aggressive wishes because of the reaction it produced in his boss.

Such compromise formations are a normal mental process (Brenner 1982). Neurotic symptoms represent only the pathological variety. Character traits themselves can be compromise formations and may represent adaptive and creative solutions to intrapsychic conflict.

Defense Mechanisms

Freud acknowledged the existence of other defense mechanisms, but he devoted most of his attention to repression. Freud's daughter Anna, in her landmark work *The Ego and the Mechanisms of Defense* (Freud 1936/1966), expanded his work by describing in detail nine individual defense mechanisms: regression, reaction formation, undoing, introjection, identification, projection, turning against the self, reversal, and sublimation. Even more important, she acknowledged the implications that this increased scrutiny of the defensive operation of the ego had for treatment. No longer could the psychoanalyst simply attend to the uncovering of unacceptable wishes from the id. Equal attention would need to be paid to the vicissitudes of defensive efforts put forth by the ego, which would manifest themselves as resistances in treatment.

In shifting the emphasis of psychoanalysis from drives to ego defenses, Anna Freud anticipated the movement of psychoanalysis and dynamic psychiatry away from neurotic symptom formation and toward character pathology. We now partially define many forms of personality disorder according to their typical defensive operations. Thus, the dynamic psychiatrist must be thoroughly familiar with a broad range of defense mechanisms because of their usefulness in understanding both neurotic problems and personality disorders.

All defenses have in common the protection of the ego against instinctual demands from the id (Freud 1926/1959). None of us is without defense mechanisms, and which defenses we use reveals a lot about us. They are often classified according to a hierarchy from the most immature or pathological to the most mature or healthy (Vaillant 1977), and a profile of one's defense mechanisms is a good barometer of psychological health. The most common defense mechanisms are listed according to this hierarchy in Table 2–1.

Although this hierarchy is in common usage in both clinical practice and research, it may imply a rigidity that is misleading. Terms such as "primitive" can have a pejorative connotation. It is more accurate to say that we are all prone to use a variety of defenses, some in the primitive category, when under stress or in large groups. Conversely, some psychiatric patients with serious disorders can use some of the more mature defenses in specific circumstances.

TABLE 2–1. A hierarchy of defense mechanisms

Defense mechanism	Description
Primitive defenses	
Splitting	Compartmentalizing experiences of self and other such that integration is not possible. When the individual is confronted with the contradictions in behavior, thought, or affect, he or she regards the differences with bland denial or indifference. This defense prevents conflict stemming from the incompatibility of the two polarized aspects of self or other.
Projective identification	Both an intrapsychic defense mechanism and an interpersonal communication, this phenomenon involves behaving in such a way that subtle interpersonal pressure is placed on another person to take on characteristics of an aspect of the self or an internal object that is projected into that person. The person who is the target of the projection then begins to behave, think, and feel in keeping with what has been projected.
Projection	Perceiving and reacting to unacceptable inner impulses and their derivatives as though they were outside the self. Differs from projective identification in that the target of the projection is not changed.
Denial	Avoiding awareness of aspects of external reality that are difficult to face by disregarding sensory data.
Dissociation	Disrupting one's sense of continuity in the areas of identity, memory, consciousness, or perception as a way of retaining an illusion of psychological control in the face of helplessness and loss of control. Although similar to splitting, dissociation may in extreme cases involve alteration of memory of events because of the disconnection of the self from the event.
Idealization	Attributing perfect or near-perfect qualities to others as a way of avoiding anxiety or negative feelings, such as contempt, envy, or anger.
Acting out	Enacting an unconscious wish or fantasy impulsively as a way of avoiding painful affect.
Somatization	Converting emotional pain or other affect states into physical symptoms and focusing one's attention on somatic (rather than intrapsychic) concerns.
Regression	Returning to an earlier phase of development or functioning to avoid the conflicts and tensions associated with one's present level of development.

TABLE 2–1. A hierarchy of defense mechanisms *(continued)*

Defense mechanism	Description
Schizoid fantasy	Retreating into one's private internal world to avoid anxiety about interpersonal situations.
Higher-level neurotic defenses	
Introjection	Internalizing aspects of a significant person as a way of dealing with the loss of that person. One may also introject a hostile or bad object as a way of giving one an illusion of control over the object. Introjection occurs in nondefensive forms as a normal part of development.
Identification	Internalizing the qualities of another person by becoming like the person. Whereas introjection leads to an internalized representation experienced as an "other," identification is experienced as part of the self. This, too, can serve nondefensive functions in normal development.
Displacement	Shifting feelings associated with one idea or object to another that resembles the original in some way.
Intellectualization	Using excessive and abstract ideation to avoid difficult feelings.
Isolation of affect	Separating an idea from its associated affect state to avoid emotional turmoil.
Rationalization	Justification of unacceptable attitudes, beliefs, or behaviors to make them tolerable to oneself.
Sexualization	Endowing an object or behavior with sexual significance to turn a negative experience into an exciting and stimulating one or to ward off anxieties associated with the object.
Reaction formation	Transforming an unacceptable wish or impulse into its opposite.
Repression	Expelling unacceptable ideas or impulses or blocking them from entering consciousness. This defense differs from denial in that the latter is associated with external sensory data, whereas repression is associated with inner states.
Undoing	Attempting to negate sexual, aggressive, or shameful implications from a previous comment or behavior by elaborating, clarifying, or doing the opposite.

TABLE 2–1. A hierarchy of defense mechanisms *(continued)*

Defense mechanism	Description
Mature defenses	
Humor	Finding comic and/or ironic elements in difficult situations to reduce unpleasant affect and personal discomfort. This mechanism also allows some distance and objectivity from events so that an individual can reflect on what is happening.
Suppression	Consciously deciding not to attend to a particular feeling, state, or impulse. This defense differs from repression and denial in that it is conscious rather than unconscious.
Asceticism	Attempting to eliminate pleasurable aspects of experience because of internal conflicts produced by that pleasure. This mechanism can be in the service of transcendent or spiritual goals, as in celibacy.
Altruism	Committing oneself to the needs of others over and above one's own needs. Altruistic behavior can be used in the service of narcissistic problems but can also be the source of great achievements and constructive contributions to society.
Anticipation	Delaying of immediate gratification by planning and thinking about future achievements and accomplishments.
Sublimation	Transforming socially objectionable or internally unacceptable aims into socially acceptable ones.

Adaptive Aspects of the Ego

The ego's importance to the psyche is not limited to its defensive operations. Heinz Hartmann established himself as one of the foremost contributors to contemporary ego psychology by focusing on the nondefensive aspects of the ego. He turned the ego away from the id and refocused it on the outside world. Hartmann (1939/1958) insisted that there was a "conflict-free sphere of the ego" that develops independently of id forces and conflicts. Given an "average expectable environment," certain autonomous ego functions present at birth are allowed to flourish without being impeded by conflict. These include thinking, learning, perception, motor control, and language, to name a few. Hartmann's *adaptive* point of view, then, is an outgrowth of his concept of the existence of an autonomous, conflict-free area of the ego. Through neutralization of sexual and aggressive energies, Hartmann be-

lieved, even certain defenses could lose their connection with the instinctual forces of the id and become secondarily autonomous or adaptive.

David Rapaport (1951) and Edith Jacobson (1964) picked up where Hartmann left off and further refined his seminal contributions to ego psychology. Bellak et al. (1973) systematized ego functions into scales used both for research and for clinical evaluation. The most important of these ego functions include reality testing, impulse control, thought processes, judgment, synthetic–integrative functioning, mastery–competence, and primary and secondary autonomy (after Hartmann).

Object Relations Theory

The view of ego psychology is that drives (i.e., sexuality and aggression) are primary, whereas object relations are secondary. (It is a well-established, although perhaps unfortunate, tradition in psychoanalytic writing to use the term *object* to mean *person*. Despite the somewhat pejorative connotations of *object,* I will retain the usage here for the sake of consistency and clarity.) In other words, the infant's most compelling agenda is tension discharge under the pressure of drives. Object relations theory, on the other hand, holds that drives emerge in the context of a relationship (e.g., the infant–mother dyad) and therefore can never be divorced from one another. Some object relations theorists (Fairbairn 1952) would even suggest that the drives are primarily geared to object seeking rather than tension reduction.

Stated in its simplest terms, object relations theory encompasses the transformation of interpersonal relationships into internalized representations of relationships. As children develop, they do not simply internalize an object or person; rather, they internalize an entire *relationship* (Fairbairn 1940/1952, 1944/1952). A prototype of loving, positive experience is formed during periods when the infant is nursing (Freud 1905/1953). This prototype includes a positive experience of the self (the nursing infant), a positive experience of the object (the attentive, caretaking mother), and a positive affective experience (pleasure, satiation). When hunger returns and the infant's mother is not immediately available, a prototype of negative experience occurs, including a negative experience of the self (the frustrated, demanding infant), an inattentive, frustrating object (the unavailable mother), and a negative affective experience of anger and perhaps terror. Ultimately, these two experiences are internalized as two opposing sets of object relationships consisting of a self representation, an object representation, and an affect linking the two (Ogden 1983).

The internalization of the infant's mother, usually referred to as *introjection* (Schafer 1968), begins with the physical sensations associated with the

presence of the mother during nursing but does not become meaningful until a boundary between inner and outer has developed. Around the sixteenth month of life, isolated images of the mother gradually coalesce into an enduring mental representation (Sandler and Rosenblatt 1962). At the same time an enduring self representation forms, first as a body representation and later as a compilation of sensations and experiences perceived as belonging to the infant.

The object that has been introjected does not necessarily correlate with the real external object. For example, a mother who is unavailable to feed her infant on demand may simply be occupied with an older sibling, but she is *experienced* and *introjected* by the infant as hostile, rejecting, and unavailable. Object relations theory acknowledges that there is *not* a one-to-one correlation between the real object and the internalized object representation.

Object relations theory also views conflict differently than it is viewed by ego psychology. Unconscious conflict is not merely the struggle between an impulse and a defense; it is also a clash between opposing pairs of internal object relations units (Kernberg 1983; Ogden 1983; Rinsley 1977). In other words, at any one time different constellations of self representations, object representations, and affects vie with one another for center stage in the intrapsychic theater of internal object relations.

Internalization of object relations always involves a splitting of the ego into unconscious suborganizations (Ogden 1983). These fall into two groups:

> (1) self-suborganizations of ego, i.e., aspects of the ego in which the person more fully experiences his ideas and feelings as his own, and (2) object suborganizations of ego through which meanings are generated in a mode based upon an identification of an aspect of the ego with the object. This identification with the object is so thorough that one's original sense of self is almost entirely lost. (Ogden 1983, p. 227)

This model clearly shows the influence of Freud's notion of the superego, which is commonly experienced as though it is a "foreign body" (i.e., an object-suborganization of the ego that monitors what a self-suborganization of the ego is doing). Ogden's model also provides a pathway back from the intrapsychic to the interpersonal. In this framework, transference can be viewed as taking one of two forms—either the role of the self-subdivision of the ego or that of the object-subdivision of the ego may be externalized onto the treater, a process that is discussed in detail later in this chapter.

A Historical Perspective

Melanie Klein is usually seen as the founder of the object relations movement. She emigrated from Budapest, and later from Berlin, to England in

1926, where her theory of early infantile development became highly controversial. She was influenced by Freud but also broke new ground in her focus on internal objects. Through psychoanalytic work with children, she evolved a theory that relied heavily on unconscious intrapsychic fantasy and that compressed the developmental timetable of classical theory into the first year of life. The Oedipus complex, for example, was viewed by Klein as coinciding approximately with weaning in the latter half of the first year.

In the first few months of life, according to Klein, the infant experiences a primal terror of annihilation connected with Freud's death instinct. As a way of defending against this terror, the ego undergoes splitting, in which all "badness" or aggression deriving from the death instinct is disavowed and projected onto the mother. The infant then lives in fear of the mother's persecution—which may be concretized as a fear that the mother will get inside the infant and destroy any goodness (deriving from libido) that has also been split off and is protected inside the infant. This latter fear is the primary anxiety of what Klein (1946/1975) termed the *paranoid-schizoid position*. This early mode of organizing experience gains its name from the prominent defense mechanisms of splitting of the ego ("schizoid") and projection ("paranoid"). Indeed, projection and introjection are crucial to understanding the paranoid-schizoid position. These mechanisms are used to separate "good" and "bad" as much as possible (Segal 1964). After persecuting, or bad, objects have been projected onto the mother to separate them from good, or idealized, objects, they may be reintrojected (i.e., taken back inside) to gain control and mastery over them. Concomitantly, the good objects may be projected to keep them safe from the "bad," which is now inside.

These oscillating cycles of projection and introjection continue until the infant begins to realize that the "bad" mother and the "good" mother are not in fact different but are the same person. As children integrate the two part-objects into one whole object, they become disturbed that their sadistic, destructive fantasies toward the mother may have destroyed her. This newfound concern for the mother as a whole object is termed *depressive anxiety* by Klein and heralds the arrival of the *depressive position*. This mode of experience involves concern that one may harm others, in contrast to the paranoid-schizoid position, in which the concern is that one will be harmed by others. Guilt becomes a prominent part of the affective life of the infant, who attempts to resolve it through *reparation*. This process may involve acts toward the mother that are designed to repair the "damage" inflicted on her in actuality or in fantasy. Klein recast the Oedipus complex as an effort to resolve depressive anxieties and guilt through reparation.

Klein's formulations have been criticized for relying exclusively on fantasy and thereby minimizing the influence of real persons in the environment, for overemphasizing the death instinct—a concept that is largely

discounted by contemporary psychoanalytic theorists—and for attributing sophisticated adult forms of cognition to infants in their first year of life. Nevertheless, her brilliant development of the paranoid-schizoid and depressive positions is of extraordinary clinical value, especially if we view these positions as two lifelong modes of generating experience that create a dialectical interplay in the mind rather than viewing them as developmental phases that are passed through or outgrown (Ogden 1986). This conceptualization of lifelong modes of experience decreases the significance of Klein's developmental timetable.

For Klein, the drives were really complex psychological phenomena intimately tied to specific object relations. Rather than originating in the body, drives were seen as merely using the body as a vehicle for expression (Greenberg and Mitchell 1983). Similarly, the drives were not viewed as simply seeking tension reduction but as being directed toward specific objects for specific reasons. During the 1940s, this perspective and others held by Klein led to acrimonious debate in the British Psychoanalytic Society. Anna Freud was Klein's principal nemesis, and when a schism finally ruptured the society, one segment, known as the B Group, followed Anna Freud's leadership, whereas the A Group remained loyal to Klein. A third segment, the Middle Group, refused to take sides. The Middle Group, to some degree influenced by Klein's thinking, created the theory of object relations as we know it today (Kohon 1986). The individuals associated with this third segment did not officially designate themselves a group until 1962, when they became known as the "Independents." Among the key figures in the Independents, sometimes referred to as the "British School" of object relations (Sutherland 1980), were D.W. Winnicott, Michael Balint, W.R.D. Fairbairn, Margaret Little, and Harry Guntrip. This group dominated the British society in terms of numbers after the Controversial Discussions of 1943 and 1944 (see King and Steiner 1992), even though there was no central figurehead who had published a coherent theory (Tuckett 1996). Although there were in fact significant differences in the writings of these thinkers, their work shared common themes. All were concerned about early development prior to the Oedipus complex, and all focused on the vicissitudes of internal object relations rather than on drive theory. Moreover, like Klein and unlike the B Group, they tended to treat sicker patients with psychoanalytic methods, perhaps thereby obtaining a more intimate glimpse of primitive mental states.

The Independents served to counterbalance Klein's overemphasis on fantasy by stressing the influence of the infant's early environment. Winnicott (1965), for example, coined the term *good-enough mother* to characterize the minimum environmental requirements needed by the infant in order to proceed with normal development. Balint (1979) described the feeling in many patients that something was missing, which he termed the *basic fault*. He

viewed this lack as caused by the mother's failure to respond to the child's basic needs. Fairbairn (1963), perhaps the most divorced from drive theory, saw the etiology of his schizoid patients' difficulties not in drive frustration but in their mothers' failure to provide experiences that reassured them they were truly loved for themselves. He believed that the instincts or drives were not pleasure seeking but rather object seeking. Moreover, Fairbairn was instrumental in introducing the idea of early trauma as a major pathogenic factor that tended to "freeze" the patient at a developmental juncture before the age of 3 years (Fonagy and Target 2003).

These thinkers were all impressed with the fact that a theory of *deficit,* as well as a theory of *conflict*, was necessary for a complete psychoanalytic understanding of the human being. Analysts have another task in addition to the analysis of conflict. They also serve as a new object to be internalized by their patients so as to bolster deficient intrapsychic structures. This point is critical for a clinical theory of object relations—the patient's internal object relations are not etched in granite; they are open to modification through new experiences.

Another key concept emerging from the British School is that an infant has an inborn tendency to grow toward self-realization (Summers 1999). Winnicott, in particular, felt that there was a *true self* whose growth could be facilitated or impeded by the responses of the mother and other figures in the environment. Bollas (1989) expanded on this view by arguing that the primary motivator within the child is the need to become himself or herself, which is facilitated by the mother's capacity to let the child express his or her true self in interaction with her. The mother who cannot serve in this facilitating capacity may contribute to the child's development of a *false self* in the service of accommodating the mother's needs and wishes.

Self and Ego

Whereas ego psychologists tend to minimize the significance of the self in their pursuit of a thorough understanding of the ego, the object relations theorists, because of their focus on the self as it relates to objects, have sought to clarify further the place of the self in the psychic apparatus. As discussed in Chapter 1, the self is an aspect of the "person" that is elusive. It comprises various components, including both subject and object, an aggregate of personal memories, unconscious distressing and disavowed aspects, context-related dimensions that emerge at different times, and culture-based phenomena. Much of the controversy in psychoanalytic writing has revolved around its status as an intrapsychic representation versus an agent that initiates thought, feeling, and action (Guntrip 1968, 1971; Kernberg 1982; Meissner 1986; Schafer 1976; Sutherland 1983).

There is room for both the self-as-representation and the self-as-agency. In fact, the self may be viewed as embedded in the ego and may be defined as the end product of the integration of the many self representations (Kernberg 1982). This integrated end product, however, should not be regarded as a continuous, unvarying entity (Bollas 1987; Mitchell 1991; Ogden 1989; Schafer 1989). Although we often wish to maintain an illusion of a continuous self, the reality is that we all are composed of multiple discontinuous selves that are constantly being shaped and defined by real and fantasized relationships with others. Schafer (1989) understood this phenomenon as a set of narrative selves or story lines that we develop to provide an emotionally coherent account of our lives. Mitchell (1991) observed that a paradox of psychoanalytic work is that as patients learn to tolerate these multiple facets of themselves, they begin to experience themselves as more durable and more coherent.

Defense Mechanisms

Because of the historical association between object relations theory and seriously disturbed patients, considerable emphasis is placed on primitive defenses characteristic of personality disorders and psychoses: splitting, projective identification, introjection, and denial.

Splitting

Splitting is an unconscious process that actively separates contradictory feelings, self representations, or object representations from one another. Although Freud (1927/1961, 1940/1964) made scattered references to splitting, it was Klein (1946/1975) who exalted it to the position of the cornerstone of emotional survival during the first few months of life. Splitting allows the infant to separate good from bad, pleasure from displeasure, and love from hate so as to preserve positively colored experiences, affects, self representations, and object representations in safely isolated mental compartments, free from contamination by negative counterparts. Splitting may be viewed as a basic biological mode of ordering experience by which the endangering is separated from the endangered; it is secondarily elaborated into a psychological defense (Ogden 1986). It is also a fundamental cause of ego weakness (Kernberg 1967, 1975). The integration of libidinal and aggressive drive derivatives associated with "good" and "bad" introjects serves to neutralize aggression. Splitting prevents this neutralization and thus deprives the ego of an essential source of energy for growth.

In Kernberg's view, splitting is characterized by certain clinical manifestations: 1) alternating expression of contradictory behaviors and attitudes,

which the patient regards with lack of concern and bland denial; 2) the compartmentalization of everyone in the environment into "all good" and "all bad" camps, which is often referred to as *idealization* and *devaluation;* and 3) the coexistence of contradictory self representations that alternate with one another. Although Kernberg viewed splitting as the key defensive operation in patients with borderline personality disorder, splitting may be observed in all patients at times (Rangell 1982), and it does not clearly differentiate borderline patients from those with other personality disorders (Allen et al. 1988). Kernberg distinguished between neurotic and borderline characters partly on the basis of the latter's preference for splitting over repression, but empirical research suggests that these two defenses operate independently and may coexist in the same individual (Perry and Cooper 1986).

Projective Identification

A second defense mechanism, projective identification, is an unconscious three-step process by which aspects of oneself are disavowed and attributed to someone else (see Figures 2–2, 2–3, and 2–4). The three steps (Ogden 1979) are as follows:

1. The patient projects a self or an object representation onto the treater.
2. The treater unconsciously identifies with what is projected and begins to feel or behave like the projected self or object representation in response to interpersonal pressure exerted by the patient (this aspect of the phenomenon is sometimes referred to as *projective counteridentification* [Grinberg 1979]).
3. The projected material is "psychologically processed" and modified by the treater, who returns it to the patient through reintrojection. The modification of the projected material, in turn, modifies the corresponding self or object representation and the pattern of interpersonal relatedness.

These three steps are presented in an artificially linear manner for the sake of clarity. However, Ogden (1992) stressed that these aspects are not truly linear but rather should be conceptualized as creating a dialectic in which the patient and analyst enter into a relationship in which they are simultaneously separate but also "at one" with each other. A unique subjectivity is created through the dialectic of an interpenetration of subjectivities. Nevertheless, transference and countertransference can be correlated with steps 1 and 2, respectively. In this regard, projective identification has an interpersonal dimension in addition to its role as an intrapsychic defense mechanism. Splitting and projective identification are highly interrelated mechanisms that work together to keep "good" and "bad" separated (Grot-

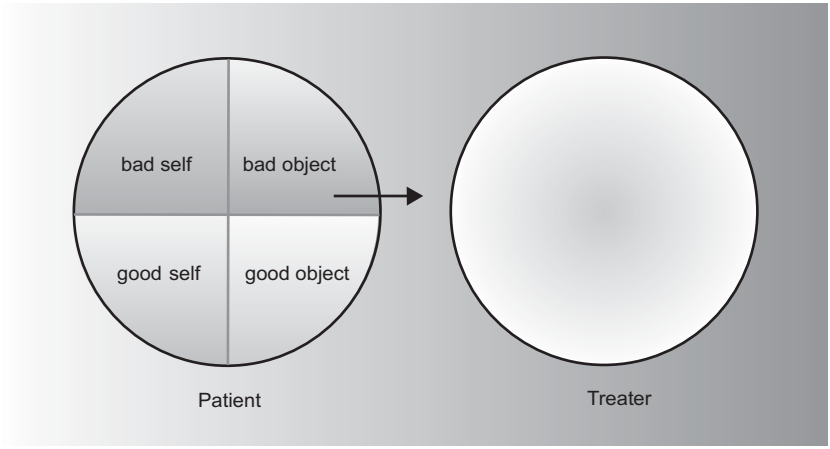

FIGURE 2–2. Projective identification—step 1. Patient disavows and projects bad internal object onto treater.

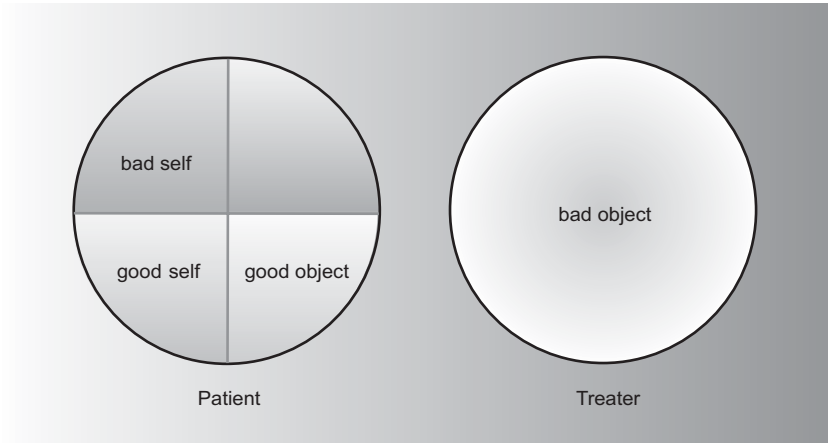

FIGURE 2–3. Projective identification—step 2. Treater unconsciously begins to feel and/or behave like the projected bad object in response to interpersonal pressure exerted by the patient (projective counteridentification).

stein 1981). The interpersonal element inherent in Ogden's definition of projective identification derives from Bion's (1962) conceptualization of the therapist as a container for the projections of the patient, much as the mother contains the projections of her infant.

Contemporary Kleinian analysts in London view projective identification somewhat differently. They are more inclined to conceptualize the de-

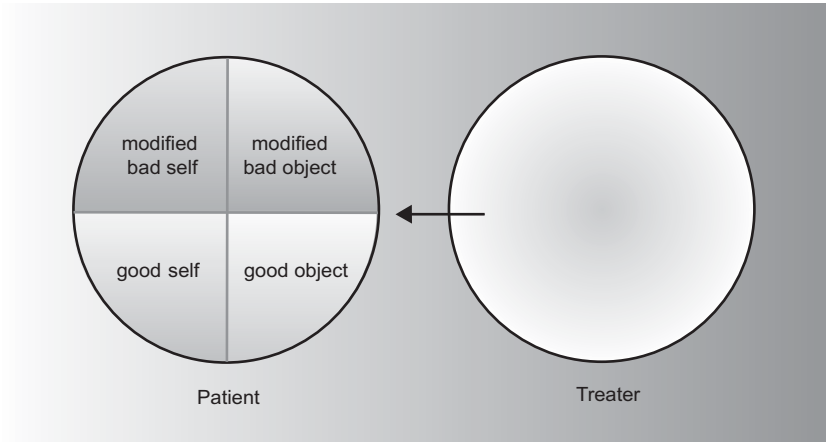

FIGURE 2–4. Projective identification—step 3. Treater contains and modifies the projected bad object, which is then reintrojected by the patient and assimilated (introjective identification).

fense as involving not the projection of a part of the patient but rather a fantasy of an object relationship (Feldman 1997). In this regard, the transformation of the target of the projection is not absolutely necessary. Nevertheless, a growing consensus is emerging from the Kleinians that the analyst or therapist is always influenced to some degree by what the patient is projecting and that some degree of responsiveness to "nudges" by the patient to act in accord with the patient's projections may help the analyst become consciously aware of what is being projected (Joseph 1989; Spillius 1992).

As noted in Chapter 1, countertransference is a joint creation involving contributions from both patient and clinician (Gabbard 1995). The patient evokes certain responses in the therapist, but it is the therapist's own conflicts and internal self- and object representations that determine the final shape of the countertransference response. In other words, the process requires a "hook" in the recipient of the projection to make it stick. Some projections constitute a better fit with the recipient than do others (Gabbard 1995).

To confine the concept of projective identification to a defense mechanism is unduly limiting. Because of the interpersonal component, it may also be regarded as 1) a means of communication, in which patients coerce the treater into experiencing a set of feelings similar to their own; 2) a mode of object relatedness; and 3) a pathway for psychological change, in the sense that the reintrojection of the projected contents after they have been modified by the treater results in a modification of the patient. Although this model of projective identification emphasizes what takes place in a clinical

setting, projective identification regularly occurs in nontherapeutic situations as well. In these nonclinical settings, the projections may be returned in completely distorted forms, or "crammed back down the patient's throat," instead of being modified or contained.

Introjection

The third defense, introjection, is an unconscious process by which an external object is symbolically taken in and assimilated as part of oneself. This mechanism may exist as a part of projective identification, where what is taken in was originally projected, or it may exist independently as the converse of projection. Classically, Freud (1917/1963) formulated depression as a result of the introjection of an ambivalently viewed object. Anger focused on this introject within the depressed patient resulted in self-depreciation and other symptoms of depression. In contemporary object relations parlance, introjection is distinguished from identification as one of the two principal modes of internalization. If a parent, for example, is *introjected,* then the parent is internalized as part of the object subdivision of the ego and is experienced as an internal presence that does not substantially alter the self representation. On the other hand, in *identification*, the parent is internalized as part of the self-subdivision of the ego and materially modifies the self representation (Sandler 1990).

Denial

The fourth defense mechanism, denial, is a direct disavowal of traumatic sensory data. Whereas repression is generally used as a defense against *internal* wishes or impulses, denial is ordinarily a defense against the external world of reality when that reality is overwhelmingly disturbing. Although associated primarily with psychoses and severe personality disorders, this mechanism may also be used by healthy people, especially in the face of catastrophic events.

American Relational Theory

The British School of object relations has greatly influenced American relational theory. This "two person" theory and its close cousins—intersubjectivity, constructivism, and interpersonal theory—have in common a view that the therapist's perceptions of the patient are inevitably colored by the therapist's subjectivity (Aron 1996; Gill 1994; Greenberg 1991; Hoffman 1992, 1998; Levine 1994; Mitchell 1993, 1997; Natterson 1991; Renik 1993, 1998; Stolorow et al. 1987). An essential feature of this view is that there are

two persons in the room mutually influencing each other at all times. Hence the therapist cannot transcend his or her own subjectivity when formulating the patient's problems. Moreover, the actual behavior of the therapist will have a substantial impact on the patient's transference. Some would argue that this intersubjective perspective transcends any particular school and is relevant to all psychotherapy situations (Aron 1996; Dunn 1995; Gabbard 1997; Levine 1996).

Over the past decade, the differences between American relational theory and the British School of object relations have become increasingly insignificant. As Harris (2011) notes, "What historically were major differences appear now as more subtle distinctions" (p. 702). Hence, geographic origins of a theory become relatively unimportant because there is considerable overlap between the British tradition and the American writers of today. Countertransference and two-person psychology are certainly at the heart of the relational movement. Acknowledgment of uncertainty and the need for improvisation in one's technique are also of critical importance to a relational/intersubjective point of view (Ringstrom 2007). The notion of the self is also prominent in writers from the interpersonal and relational tradition. Bromberg (2006) emphasizes that shame-based self states are intolerable and may be split off or dissociated in such a way that false continuities and incoherences may be a prominent feature of the psychotherapeutic work. Finally, the acknowledgment of uncertainty in the process places considerable emphasis on the need for negotiation between therapist and patient around meaning and the optimal approach to the therapy itself (Bass 2007; Pizer 2004). The analyst's or therapist's view is not privileged over the subjective perspective of the patient as it often was in the history of classical psychoanalysis.

Self Psychology

Kohut

Whereas object relations theory emphasizes the *internalized* relationships between *representations* of self and object, self psychology stresses how *external* relationships help maintain self-esteem and self-cohesion. Derived from the seminal writings of Heinz Kohut (1971, 1977, 1984), this theoretical approach views the patient as being in desperate need of certain responses from other persons to maintain a sense of well-being.

Self psychology evolved from Kohut's study of narcissistically disturbed outpatients he was treating in psychoanalysis. He noted that they seemed different from the classic neurotic patients who presented for treatment with hysterical or obsessive-compulsive symptoms. Instead, they complained of

nondescript feelings of depression or dissatisfaction in relationships (Kohut 1971). They were also characterized by a vulnerable self-esteem that was highly sensitive to slights from friends, family, lovers, colleagues, and others. Kohut observed that the structural model of ego psychology did not seem adequate to explain the pathogenesis and cure of these patients' problems.

Kohut noted that these patients formed two kinds of transferences: the mirror transference and the idealizing transference. In the mirror transference the patient looks to the analyst for a confirming, validating response that Kohut linked to the "gleam in the mother's eye" in response to phase-appropriate displays of exhibitionism on the part of her small child—what Kohut called the *grandiose-exhibitionistic self*. These approving responses, according to Kohut, are essential for normal development in that they provide the child with a sense of self-worth. When a mother fails to empathize with her child's need for such a mirroring response, the child has great difficulty in maintaining a sense of wholeness and self-regard. In response to this failure of empathy, the child's sense of self fragments, and the child desperately attempts to be perfect and to "perform" for the parent to gain the hungered-for approbation. This form of "showing off" is another manifestation of the grandiose-exhibitionistic self (Baker and Baker 1987). The same phenomena constitute the mirror transference in adults who seek treatment. The adult patient who "performs" for his or her therapist in a desperate attempt to gain approval and admiration may be developing a mirror transference.

The idealizing transference, as implied in the name, refers to a situation in which the patient perceives the therapist as an all-powerful parent whose presence soothes and heals. The wish to bask in the reflected glory of the idealized therapist is a manifestation of this transference. Just as the child may be traumatized by the empathic failures of a mother who does not provide mirroring responses to her child's grandiose-exhibitionistic self, so can that same child be traumatized by a mother who does not empathize with the child's need to idealize her or who does not provide a model worthy of idealization.

In either case, the adult patient who has such early disturbances of parenting and who presents these kinds of transference dispositions is struggling with a defective or deficient self—one that is developmentally frozen at a point at which it is highly prone to fragmentation. Kohut's view was that the structural model of conflict associated with ego psychology is not sufficient to explain these narcissistic needs for mirroring and idealization. Moreover, he noted a moralizing, pejorative tone in the attitudes of analysts who approached narcissism from a classical point of view. He believed that much harm was done by following Freud's (1914/1963) model, which proposed a transition from a state of primary narcissism to object love as part of the normal maturational process. The offshoot of Freud's thinking was that

one should "outgrow" narcissistic strivings and be more concerned about the needs of others.

Kohut thought that this point of view was hypocritical. He asserted that narcissistic needs persist throughout life and that they parallel development in the realm of object love. He postulated a *double-axis* theory (see Figure 2–5) that allowed for ongoing development in *both* narcissistic and object love realms (Ornstein 1974). As infants mature, they attempt to capture the lost perfection of the early maternal–infant bond by resorting to one of two strategies—the grandiose self, where the perfection is captured within, and the idealized parent imago, where it is assigned to the parent. These two poles constitute the *bipolar self.* In his last book (posthumously published), Kohut (1984) expanded this conceptualization to a *tripolar* self by adding a third pole of selfobject needs, the *twinship* or *alter ego.* This aspect of the self appears in the transference as a need to be just like the therapist. It has its developmental origins in a wish for merger that is gradually transformed into imitative behavior. For example, a young boy might play at lawn mowing while his father cuts the grass. This third pole of the self has limited clinical usefulness compared with the other two and is often excluded from discussions of selfobject transferences. If failures of empathy were typical of the parental responses to these strategies, a developmental arrest occurs. With adequate parenting, on the other hand, the grandiose self is transformed into healthy ambitions, and the idealized parent imago becomes internalized as ideals and values (Kohut 1971). Hence, therapists could empathize with the narcissistic needs of their patients as developmentally normal rather than regarding them with contempt for being self-centered and immature. Whereas classical ego psychological theory conceptualizes the patient as having infantile wishes that need to be renounced, Kohut regarded patients as having *needs* that must be understood and partially met in the treatment (Eagle 1990). Kohut's first book proposed this theoretical formulation as applicable primarily to narcissistic character pathology. By the time his last book appeared, he had greatly expanded the scope of self psychology:

> Self psychology is now attempting to demonstrate. . .that all forms of psychopathology are based either on defects in the structure of the self, on distortions of the self, or on weakness of the self. It is trying to show, furthermore, that all these flaws in the self are due to disturbances of self-selfobject relationships in childhood. (Kohut 1984, p. 53)

The term *selfobject* came to be a generic term to describe the role that other persons perform for the self in regard to mirroring, idealizing, and twinship needs. From the standpoint of the growth and development of the self, others are not regarded as separate persons but as objects to gratify these needs of the self. In a sense, then, selfobjects may be viewed more as func-

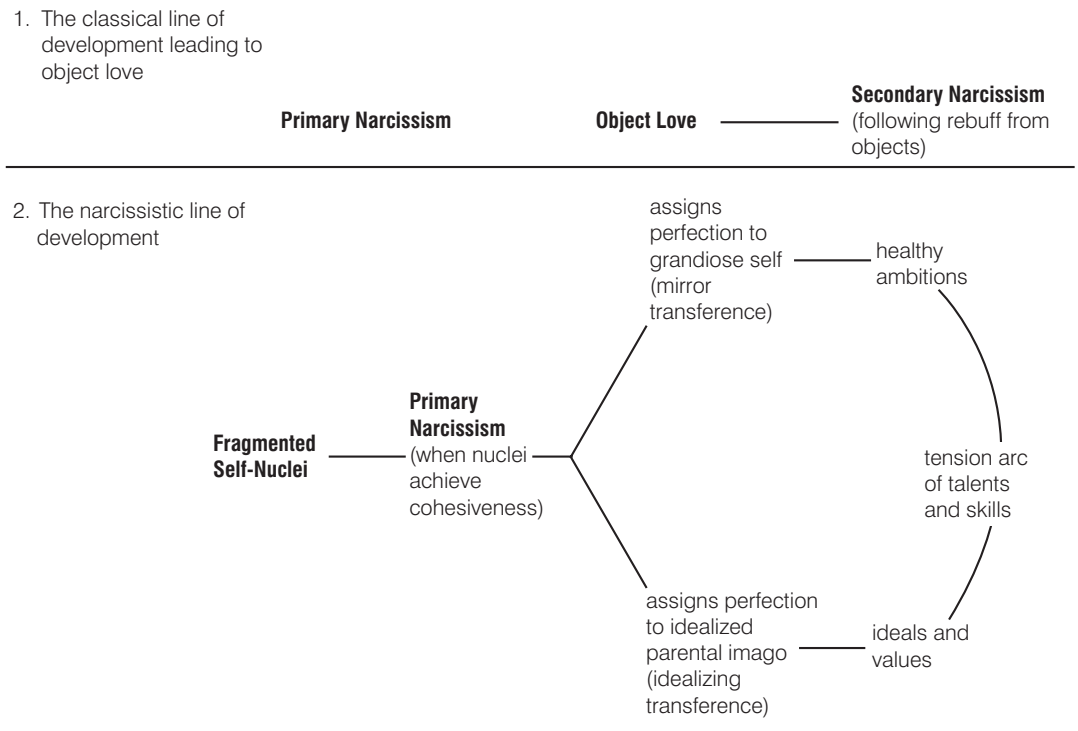
1. The classical line of development leading to object love
Primary Narcissism
Object Love
Secondary Narcissism
(following rebuff from objects)
2. The narcissistic line of development
Fragmented Self-Nuclei
Primary Narcissism
(when nuclei achieve cohesiveness)
assigns perfection to grandiose self (mirror transference)
healthy ambitions
tension arc of talents and skills
assigns perfection to idealized parental imago (idealizing transference)
ideals and values

FIGURE 2–5. Kohut's (1971) double-axis theory.

tions (e.g., soothing, validating) than as people. The need for selfobjects is never outgrown, according to Kohut, but rather persists throughout life—we need selfobjects in our environment for emotional survival much as we need oxygen in the atmosphere for physical survival (Kohut 1984).

One implication of Kohut's final theoretical statement is that psychological separation is a myth. Self psychology views the separation of the self from the selfobject as impossible. We all need affirming, empathic responses from others throughout life to maintain our self-esteem. Maturation and growth move away from a need for archaic selfobjects toward an ability to use more mature and appropriate selfobjects. In the clinical setting, the goal of treatment is to strengthen the weakened self so it can tolerate less than optimal selfobject experiences without a significant loss of self-cohesion (Wolf 1988).

Kohut always resisted a simple definition of the self, which he believed was such an overarching structure that it defied crisp definition. However, by the time of his death in 1981, his view of the self had clearly gone from that of a self representation to that of a "supraordinate self as the primary psychic constellation, the center of experience and initiative and the main motivating agency" (Curtis 1985, p. 343). Further implications include a pervasive deemphasis on the ego and the vicissitudes of drives and defenses, a greater focus on conscious subjective experience, and the conceptualization of aggression as secondary to failures of selfobjects (e.g., narcissistic rage) rather than as a primary or innate drive. Defenses and resistances in this framework, or "defense-resistances," as Kohut (1984) came to refer to them, are viewed entirely differently: "My personal preference is to speak of the 'defensiveness' of patients—and to think of their defensive attitudes as adaptive and psychologically valuable—and not of their 'resistances'" (p. 114). Clearly, they are valuable and adaptive because they preserve the integrity of the self.

In contrast to the ego psychologists, Kohut viewed the Oedipus complex as of secondary importance. The oedipal conflicts involving sexuality and aggression are mere "breakdown products" of developmentally earlier failures in the self–selfobject matrix. If a mother adequately fulfills the selfobject needs of her child, the Oedipus complex can be weathered without the child's becoming symptomatic. The fundamental anxiety, according to self psychology, is "disintegration anxiety," which involves the fear that one's self will fragment in response to inadequate selfobject responses, resulting in an experiencing of a nonhuman state of psychological death (Baker and Baker 1987). From the standpoint of self psychology, most forms of symptomatic behavior (e.g., drug abuse, sexual promiscuity, perversions, self-mutilation, binge eating, and purging) do *not* grow out of neurotic conflict related to castration anxiety. Rather, they reflect "an emergency attempt to maintain and/or

restore internal cohesion and harmony to a vulnerable, unhealthy self" (Baker and Baker 1987, p. 5). These fragmentations of the self occur along a continuum that ranges from mild worry or anxiety to severe panic over the perception that one is completely falling apart (Wolf 1988).

The emphasis of self psychology on the failures of parenting figures and the resulting deficiencies of the self resonate with the British object relations theories. Echoes of Winnicott's good-enough mothering and Balint's basic fault can be heard in the themes of self psychological writings. Although Kohut does not acknowledge the contributions of these theorists, their influence is unmistakable. However, the object relations theorists did not develop the notion of the self to the extent that Kohut did, perhaps because of their adherence to a model of maturation that retains the moralizing potential eschewed by Kohut (Bacal 1987). Kohut also has made a significant contribution in recognizing the significance of self-esteem in the pathogenesis of psychiatric disturbances. For example, personality disorders can be viewed as disorders of the self manifested by desperate attempts to preserve self-cohesion that often result in problematic relationships with others (Silverstein 2007). Similarly, the role of the therapist shifts more to a sustained empathic effort rather than interpretive understanding, with the goal of providing a selfobject experience that will be healing of the personality disorder through a form of corrective emotional experience with the therapist. In other words, the provision of empathy for a prolonged period of time would be the optimal form of therapeutic action rather than emphasizing insight about patterns and relationships with others.

Post-Kohut Contributions

After Kohut's death, a new generation of self psychologists elaborated and expanded aspects of his theory. Wolf (1988) identified two other selfobject transferences. The *adversarial selfobject transference* is one in which the patient experiences the analyst as a benignly opposing individual who nevertheless maintains some degree of supportiveness. The analyst is also perceived as encouraging a measure of autonomy for the patient's self by accepting the patient's need to be adversarial. The second selfobject transference observed by Wolf is related to the mirror transference, but because of its relationship to an intrinsic motivation to achieve mastery, it is sufficiently different to warrant a unique title. Known as the *efficacy selfobject transference,* it involves a perception by the patient that the analyst is allowing the patient to effectively produce necessary selfobject behavior in the analyst.

Other analysts influenced by self psychology believe that information outside the empathic–introspective mode of perception must be integrated into the analyst's knowledge base. Lichtenberg (1998; Lichtenberg and Had-

ley 1989) regards knowledge of "model scenes" prototypical of childhood and infant experiences as highly relevant to reconstructing and understanding the patient's early experience. He argued that five discrete motivational systems must be taken into account to fully understand the forces at work in the patient. Each of these systems is based on innate needs and associated patterns of response. One system develops in response to the need for attachment and affiliation. The second system involves responses to the need for psychic regulation and physiological requirements. The third system evolves in response to the need for assertion and exploration. The fourth system is responsive to the need to react to aversive experiences through withdrawal and/or antagonism. The fifth system involves responses to the need for sensual enjoyment and, ultimately, sexual excitement. These systems are in dialectical tension with one another and undergo continuous hierarchical rearrangement. Each of the five systems can develop only in the presence of a reciprocal response from caregivers. Lichtenberg had reservations about Kohut's theory because of its tendency to relegate sexual and nonsexual pleasure to a relatively peripheral position.

Bacal and Newman (1990) sought to integrate self psychology with object relations theory. They argued that self psychology can be understood as a variant of object relations theory and that Kohut failed to acknowledge the influence of the British School of object relations on his ideas. Bacal and Newman point out that the self in connection with its object, rather than in isolation, is the true basic unit of self psychology.

Other revisionists have questioned the mode of therapeutic action endorsed by Kohut, which involves optimal frustration of the patient's needs in the context of empathic understanding. Although Kohut repeatedly emphasized that his technique was essentially interpretive, some observers (e.g., Siegel 1996) have stressed that his approach was quite different from the type of frustration proposed by Freud. In his last book, Kohut acknowledged the role of corrective emotional experience. Nevertheless, Bacal (1985) was critical of Kohut's notion of optimal frustration and suggested that "optimal responsiveness" was just as important to the analytic process. Lindon (1994) had similar concerns and proposed the term *optimal provision* to address the problem of too much abstinence on the part of the analyst. However, he did not view this type of provision as curative. Rather, Lindon's conception of provision involved creation of an atmosphere to facilitate exploration of the patient's unconscious, not necessarily to repair developmental defects. He stipulated that provisions should be in the service of furthering analytic work rather than subversions of the analytic process.

Finally, the post-Kohut self psychologists recognize that a shift away from the lived subjective experience emphasized by Kohut is taking place within the field. In keeping with the work of Stern (2004) and the Boston

Change Process Study Group (2010), there is a greater interest in what is *implicit* as well as what is subjectively felt (Coburn 2006). In this regard there is greater awareness of the intersubjective aspects of development and the procedural implicit knowledge that is "in one's bones" even if not consciously experienced.

Developmental Considerations

To some extent, all psychoanalytic theories are based on developmental thinking. Just as psychoanalytic theory has evolved from an emphasis on drives, defenses, and intrapsychic conflict between agencies into concerns with self, object, and relationships, so too has developmental research moved in that direction. The early theories of development associated with ego psychology focused on libidinal zones and were largely reconstructions of early development based on psychoanalytic work with adults. Erikson (1959), following the lead of Hartmann, made an effort to weave interagency conflict into the broader fabric of ego psychology. He focused on psychosocial issues from the environment, which allowed him to evolve an epigenetic developmental scheme characterized by a psychosocial crisis at each phase. For example, during the oral phase of development, the infant must struggle with basic trust versus basic mistrust. The crisis of the anal phase involves autonomy versus shame and doubt. During the phallic-oedipal phase, the child grapples with initiative versus guilt.

The oedipal phase of development begins around age 3 years and is associated with a more intense focus on the genitals as the source of pleasure. Accompanying this interest is an intensified longing to be the exclusive love object of the parent of the opposite sex. However, at the same time, the child's dyadic or mother–child frame of reference changes to a triadic one, with the child becoming aware of a rival for the affections of the parent of the opposite sex.

In the case of the male child, the first love object is the mother, which does not require a shift of affection. He desires to sleep with her, caress her, and be the center of her world. Because the father interferes with these plans, the child develops murderous wishes toward his rival. These wishes result in guilt, fear of retaliation by the father, and a sense of anxiety about that impending retaliation. Freud repeatedly observed that the leading source of the male child's anxiety during this phase of development is that the father's retaliation will come in the form of castration. To avoid this punishment, the boy renounces his sexual strivings for his mother and identifies with his father. This identification with the aggressor carries with it the decision to look for a woman *like* the mother so that the boy can be *like* his father. As

part of this oedipal resolution, the retaliatory father is internalized around the end of the fifth or sixth year, forming the superego, which Freud viewed as heir to the Oedipus complex. Contemporary thinking about the oedipal phase of development has clarified that there is also a libidinal longing for the *same-sex* parent associated with a wish to be rid of the *opposite-sex* parent. This view is often referred to as the *negative Oedipus complex*.

Freud had more difficulty explaining girls' oedipal development. In a series of papers (Freud 1925/1961, 1931/1961, 1933/1964), he frankly acknowledged his bewilderment by female psychology, yet he struggled to chart female development. One way he dealt with this difficulty was to assume that females' development was basically analogous to that of males. As Freud saw it, whereas in boys the Oedipus complex is resolved by the castration complex, in girls it is *promulgated* by an awareness of "castration." In the preoedipal phases of development, in Freud's view, the little girl feels essentially like a little boy until she discovers the existence of the penis. At that point, she begins to feel inferior and falls victim to penis envy. She tends to blame her mother for her inferiority, so she turns to her father as her love object, and the wish for a child from her father replaces her wish for a penis. Freud believed that one of three paths was available to the female child after discovery of her "genital inferiority": 1) cessation of all sexuality (i.e., neurosis); 2) a defiant hypermasculinity; or 3) definitive femininity, which entailed renunciation of clitoral sexuality. In the normal oedipal resolution, loss of the mother's love, rather than fear of castration by the father, was postulated as the key factor.

More contemporary psychoanalytic authors have raised serious questions about Freud's formulation of female development. Stoller (1976) disagreed with Freud about the evolution of femininity as a product of sexual differentiation, penis envy, and unconscious conflict. He felt that femininity was an inborn potential and that a confluence of sex assignment at birth, parental attitudes, neurophysiological fetal brain organization, early interactions between the infant and the parents, and learning from the environment formed a complex nucleus around which a mature sense of femininity would ultimately become organized. He termed this first step *primary femininity* because it was not viewed as a product of conflict. Tyson (1996) stressed that mature femininity begins with primary femininity but that conflict resolution, as well as identifications made with both parents, will ultimately determine the final form.

Stoller shared the view of other authors, such as Lerner (1980) and Torok (1970), that penis envy is only one aspect of the development of femaleness, not the origin of it. Contemporary feminist psychoanalytic theory has stressed the adverse therapeutic implications of viewing penis envy as a "bedrock" phenomenon (Freud 1937/1964) that defies further analysis and understanding. One hazard of the "bedrock" view is that it may lead to a mis-

guided attempt on the part of therapists to help female patients accept a view of themselves as inferior forms of males. Frenkel (1996) stressed that female patients do not generally feel that their genitalia or genital arousal is inadequate, in contrast to Freud's thinking, and that the clitoris, far from being viewed as an inferior organ, is a locus for the initiation of intense pleasure and occasional orgasm as early as ages 4–6 years. Vaginal awareness also is present at that age. Current thinking about the construction of gender emphasizes the influence of culture, object relations, and identifications with parents rather than narrowly tying it to anatomic differences (Benjamin 1990; Chodorow 1996).

Neuroscience research has also expanded our knowledge of male-female differences. The areas of the brain involved in facial discrimination are more developed in females than males from early in life (McClure 2000). In fact, neurological maturation of the brain in general proceeds at a faster rate in females versus males (Moore and Cocas 2006). The connectivity between the right and left hemispheres is shown to be greater in females than in males (Friedman and Downey 2008). Hence, the earlier lateralization of the female brain may result in the superior capacity to sensitively read emotions on the faces of others. Although these neurobiological gender differences are significant, they in no way overshadow the extraordinary importance of the early rearing environment in the development of the female. The interactions with the parents and other key caregiving figures are central to the shaping of the individual—that is, biology and environment are mutually influential in gender formation (Silverman 2010).

The contemporary perspective about femininity within psychodynamic thinking is perhaps best characterized by a systematic questioning of received wisdom. Chodorow (2012) emphasizes that there are many femininities just as there are many masculinities, and the clinician must not approach a female patient by listening for the confirmation of specific theories. Rather, the optimal psychotherapeutic position is to recognize that there are a host of cultural, intrapsychic, and biological factors that lead to a unique individuality in each woman. Chodorow (2012) argues for an open-mindedness to discovery of the uniqueness that defines the individual:

> Although anyone's gender always includes some recognition of the difference between feminine and masculine, a particular individual's personal animation of gender may or may not be organized around the masculine-feminine difference. Even in those cases when it is, moreover, genital awareness or feelings of genital difference between the sexes may or may not form its center. (p. 147)

Development, whether involving gender identity or formation of the self, is lifelong. Development does not cease with the resolution of the Oe-

dipus complex. Defensive constellations change with each succeeding phase—latency, adolescence, young adulthood, and old age. In fact, Vaillant (1976) documented an orderly shift during adult life from immature defenses to more mature defenses such as altruism and sublimation, suggesting that personality is truly dynamic and malleable over the entire life cycle. Moreover, whereas analytic therapy was once thought to be less useful in elderly patients, now it is commonplace to use psychodynamic methods in patients in their 60s, 70s, and 80s.

Mahler

Since the 1970s, a much more empirically based developmental theory has emerged in psychoanalysis. The infant observation studies of Margaret Mahler and her colleagues (1975) were among the earliest such studies and are often viewed as providing a bridge between ego psychology and object relations theory. Through observation of normal and abnormal mother–infant pairs, Mahler and her group were able to identify three broad phases of the development of object relations.

In the first 2 months of life, an *autistic* phase occurs in which the infant appears self-absorbed and concerned with survival rather than relatedness. The period between 2 and 6 months, denoted as *symbiosis,* begins with the smile response of the infant and the visual ability to follow the mother's face. Although the infant is vaguely aware of the mother as a separate object, the infant's primary experience of the mother–infant dyad is one of a dual unity rather than of two separate people.

The third phase, *separation-individuation,* is characterized by four subphases. Between 6 and 10 months, in the first subphase of *differentiation,* the child becomes aware that the mother is a separate person. This awareness may lead to the child's need for a transitional object (Winnicott 1953/1971), such as a blanket or pacifier, to help deal with the fact that the mother is not always available. *Practicing* is the next subphase, which occurs between 10 and 16 months. With the newfound locomotor skills of this age, toddlers love to explore the world on their own, although they frequently return to their mothers for "refueling." The third subphase, *rapprochement,* is characterized by a sharper awareness of the separateness of the mother and occurs between 16 and 24 months of age. This awareness brings with it a heightened sense of vulnerability to separations from the mother.

The fourth and final phase, a subphase of separation-individuation, is marked by consolidation of individuality and the beginnings of object constancy. The achievement of this period, which roughly corresponds to the third year of life, is integration of split views of the mother into a unified whole object that can be internalized as an emotionally soothing inner pres-

ence that sustains the child during the mother's absence. This achievement corresponds with Klein's depressive position and sets the stage for the child to enter the oedipal phase.

Stern and Beyond

As noted earlier, however, Kohut's perspective challenged Mahler's emphasis on separation-individuation by suggesting that some form of selfobject response from others in the environment was essential throughout life. In addition, the infant observation research of Daniel Stern (1985, 1989) called into question the idea that infants emerge from the womb in a state of autistic self-absorption. Stern's work demonstrated that the infant seems to be aware of the mother or caretaker from the first days of life. In keeping with Kohut's ideas, Stern observed that affirming and validating responses from the mothering figure is crucial to the developing infant's evolving sense of self. He further stressed that the infant develops a sense of self-with-other in response to the caretaker's attunement. Stern differed with Klein in that he regarded fantasy as having only minimal significance. By contrast, he viewed the infant as primarily experiencing reality. He concluded that infants are adept observers of reality and that it is only as older toddlers that they begin to make significant use of fantasy and distortion in an effort to alter their perceptions.

Stern described five discrete senses of self. Rather than viewing these as phases that are superseded by subsequent and more mature developmental periods, he regarded them as different domains of self-experience (emergent or "body" self, core self, subjective self, verbal or categorical self, and narrative self), each of which remains for the entire life span and operates in concert with the other coexisting senses of self. From birth to 2 months of age, an *emergent self* appears that is predominantly a physiologically based body self. From 2 to 6 months, a *core* sense of self emerges that is linked with greater interpersonal relatedness. A sense of *subjective self* appears between 7 and 9 months and is a major event because it involves the matching of intrapsychic states between infant and mother. Between 15 and 18 months of age, coinciding with the ability to think symbolically and to communicate verbally, the *verbal* or *categorical* sense of self emerges. The *narrative* sense of self arrives between 3 and 5 years of age. Stern believed this historical view of self is encountered when patients tell their life stories in the analytic setting.

Throughout his writing, Stern (2004) emphasizes that human existence is a fundamentally social existence. We emerge from an "intersubjective matrix" that is the result of sensitive affective attunement from mothers and caretakers. Stern's understanding of this interconnectedness is much like

Kohut's in that he thinks the responses of others to us are like oxygen in the environment. As he puts it, "We need the eyes of others to form and hold ourselves together" (Stern 2004, p. 107). He strongly believes that the desire for relating in an intersubjective way is just as strong of a motivational system as the biological drives.

The concept that development proceeds in a self–other format has been extensively validated in further developmental research (Beebe et al. 1997; Fogel 1992). In accord with Kohut's and Winnicott's theoretical views, what is emerging is a dyadic systems view of communication between mother and infant that results in the internalization of a self-in-relation-to-object. In other words, as Fairbairn stressed, it is not an object but an object *relationship* that is internalized in development. What is represented by the infant is an interactive process, complete with a patterned sequence of movements, the rules for regulating these movements, and the self-regulatory consequences to the infant (Beebe et al. 1997). In keeping with postmodernist views, developmental research is suggesting that all face-to-face interaction is jointly constructed or bidirectionally regulated (Fogel 1992).

Posner and Rothbart (2000) studied arousal regulation and found that the early parent–infant interaction is crucial to regulate tension in the infant. Meins et al. (2001) examined how mothers talk to their 6-month-old infants. They concluded that self-formation was facilitated by making comments to the child that reflect the child's mental state and treat the child like a person. Hence these developmental studies confirm the importance of parental empathy on the development of the child's self.

Research examining the neural substrate for empathy underscores the developmental importance of sensitive attunement by a caregiver or parent in the development of the child. Empathy requires the capacity to map another person's feelings onto one's own nervous system (Leslie et al. 2004). Mirror neurons, first discovered in monkeys, where they were detected to have the unusual property of firing during both action execution and the observation of the same action in others, may play a crucial role. These neurons in the premotor cortex respond when a primate observes certain hand movements performed by another primate or by a human, or when the animal performs the same movements. In other words, they encode object-oriented actions, whether they are performed or observed. This group of neurons in the ventral premotor cortex are activated during observation of an agent acting in a purposeful way upon objects. Fogassi and Gallese (2002) suggested that mirror neurons may be involved in goal detection and therefore in understanding what is happening inside another person's mind. Functional imaging studies suggest that a right-hemisphere mirroring system may be critical for processing emotions in others (Leslie et al. 2004). A growing consensus in the developmental literature is that early experiences of parental

or caregiver responses initially regulate affects and eventually lead to internal working models or representations of the relationship, which continue internal regulatory functions (Hofer 2004). The right orbitofrontal region is thought to be essential in the development of internalized representations of relationships that ultimately act as biological regulators (Schore 1997).

As noted in Chapter 1, development generally is the outgrowth of the combined influence of genetic predisposition and environmental influences. Many psychoanalytic developmental theories neglect genetic factors in their formulations, and a contemporary theory must supplement pure psychoanalytic theorizing with knowledge from empirical research on gene–environment interactions. For example, Reiss et al. (2000) emphasized that genetic characteristics of the child elicit certain parental responses that may in turn influence which genes are expressed and which are suppressed.

Attachment Theory

The fourth major theory relevant to dynamic psychiatry is one that is rooted in empirical research—attachment theory. Although John Bowlby's seminal works on the subject (Bowlby 1969, 1973, 1980) have been around for a long time, only recently has attachment theory enjoyed a wide psychoanalytic audience. Attachment is a biologically based bond between the child and the caregiver that is designed to ensure the safety and survival of the child. In contrast to object relations theory, attachment theory posits that the goal of the child is not to seek an object but rather to seek a physical state achieved by proximity to the mother/object (Fonagy 2001). As development proceeds, the physical goal is transformed into a more psychological one of gaining a feeling of closeness to the mother or caregiver. Secure attachment strongly influences the development of internal working models of relationships that are stored as mental schemas and lead to experiences regarding the expectations of the behavior of others toward the self.

Attachment strategies, which are largely independent of genetic influences, are adopted in infancy and remain relatively stable. Ainsworth et al. (1978) studied these strategies in a laboratory scenario known as the Strange Situation. This situation, involving a toddler's separation from the caregiver, tended to elicit one of four behavioral strategies. *Secure* infants simply sought proximity with the caregiver upon her return and then felt comforted and returned to play. *Avoidant* behavior was seen in infants who appeared less anxious during the separation and snubbed the caregiver on her return. These infants showed no preference for the mother or caregiver over a stranger. In a third category, termed *anxious-ambivalent* or *resistant,* infants showed great distress at separation and manifested angry, tense, and clinging

behavior when the caregiver returned. A fourth group, termed *disorganized-disoriented,* had no coherent strategy whatsoever to deal with the experience of separation.

Multiple studies have demonstrated that the parents' attachment status will predict not only whether a child will be securely attached but also the precise attachment category in the Strange Situation (Fonagy 2001). Nevertheless, it is also true that biological temperament, which is genetically based, may influence the child's response to caregiving by an attachment figure (Allen 2013). Conversely, temperament can be subject to environmental influence and can change over time because of the quality of caretaking and attachment. As noted in Chapter 1, inborn temperaments that predispose one to the development of shyness or social anxiety may be positively influenced by the quality of the environmental caregiving.

There is some evidence that these attachment patterns have continuity into adulthood, and these categories of attachment style can be measured with sophisticated interviews (George et al. 1996). The four responses to the Strange Situation correspond respectively to adult categories of attachment as follows: 1) secure/autonomous individuals who value attachment relationships; 2) insecure/dismissing individuals who deny, denigrate, devalue, or idealize past and current attachments; 3) preoccupied individuals who are confused or overwhelmed by both past and current attachment relationships; and 4) unresolved or disorganized individuals who often have suffered neglect or trauma. A survey of all of the longitudinal studies testing the stability of attachment classification from childhood to adulthood suggests a range from minimal continuity to high stability (George and Solomon 2008). This research reflects many factors that may be associated with changes in security from infancy to adulthood. These include stressful life events, parental death, social support, family functioning, divorce, and serious illness in either parents or children. Hence, we must conclude that early attachment patterns are not necessarily etched in granite.

Attachment theory has made significant contributions to our understanding of what motivates human beings. Sexuality, aggression, and self-cohesion all are relevant to understanding adult patients who come for psychotherapy. However, Joseph Sandler (2003) recognized that the search for safety is also a primary motivating factor, and he derived this understanding in part from the findings of attachment theory and research. Moreover, in contrast to the Kleinian emphasis on intrapsychic fantasy, attachment theory places real neglect, abandonment, and other early traumas, as well as the mental processing of those traumas, at center stage in psychoanalytic theory. A large body of evidence suggests that disorganized attachment is a vulnerability factor for later psychiatric disturbance and that attachment security can serve as a protective factor against adult psychopathology (Fonagy and Target 2003).

Some research suggests that attachment security or the lack of it may predict certain types of personality disorder. Incoherent/disorganized attachment is uniquely associated with a history of childhood trauma and disrupted attachments. Hence, borderline personality disorder is linked to both preoccupied and incoherent/disorganized attachment (Westen et al. 2006).

The caregiver's capacity to observe the infant's intentional state and internal world appears to influence the development of secure attachment in the child. A key concept in attachment theory is *mentalization,* which refers to the capacity to understand that one's own and others' thinking is representational in nature and that one's own and others' behavior is motivated by internal states, such as thoughts and feelings (Fonagy 1998). Parents or caregivers who themselves have the capacity to mentalize tune in to the infant's subjective mental state, and the infant ultimately finds himself or herself in the caregiver's mind and internalizes the caregiver's representation to form a core psychological self. In this manner, the child's secure attachment to the caregiver engenders the child's capacity to mentalize. In other words, through the interaction with the caregiver, the child learns that behavior can best be understood by assuming that ideas and feelings determine a person's actions.

Mentalizing is often referred to as having a "theory of mind." Much of what happens in a clinical interaction, especially psychotherapy, depends on the clinician's ability to understand the minds of others. True mentalization becomes possible between the ages of 4 and 6 years, and recent neuroimaging studies suggest the medial prefrontal cortex, the temporal poles, the cerebellum, and the posterior-superior temporal sulcus may all be involved as components of a mentalization network (Calarge et al. 2003; Frith and Frith 2003; Sebanz and Frith 2004).

Role of Theory in Clinical Practice

Faced with a bewildering array of psychoanalytic theories, one may choose to deny the value of theory altogether. Who needs it? Why not just begin de novo with each patient and stick to the clinical material? To advocate this approach is simply to advocate the formation of new theories. As Kernberg (1987) noted, "All observations of clinical phenomena depend upon theories, and when we think that we are forgetting about theory, it only means that we have a theory of which we are not aware" (pp. 181–182).

A more sensible solution is to become familiar with the phenomena described by all the major theories and to focus on each perspective as it is clinically appropriate with a given patient (Gabbard 2007). Psychoanalysis and psychodynamic psychiatry are tragically beset with needless polarities—is it oedipal or preoedipal, conflict or deficit, classical theory or self psychology,

tension reduction or object seeking? Such questions tend to be cast in terms of right or wrong. Yet is it possible that different models are valid in different clinical situations? Is it not possible for both oedipal and preoedipal, conflict and deficit, to be relevant in the understanding of an individual patient? Of course it is.

Some aspects of all the theoretical perspectives examined in this chapter will most likely prove useful in the treatment of patients. From a developmental perspective, certain aspects of early childhood experience are better explained by one theory than another, and with certain patients, the emphasis will be more in one direction than another, depending on the clinical data (Pine 1988). In most patients, however, we will find both deficit and conflict. As Eagle (1984) noted in his appraisal of the role of theory in psychoanalysis: "We are most conflicted in the areas in which we are deprived.…It is precisely the person deprived of love who is most conflicted about giving and receiving love" (p. 130). In practice, clinicians find themselves serving both as selfobjects and as real, separate objects for their patients.

For some clinicians, however, shifting from one theoretical perspective to another, depending on the patient's needs, is too cumbersome and unwieldy. Wallerstein (1988) pointed out that it is possible for clinicians to pay attention to the *clinical phenomena* described by each theoretical perspective without embracing the entire metapsychological model. For example, one can address self and object representations, mirror and idealizing transferences, and impulse-defense configurations as they appear in the clinical setting without having to resort to invoking the entire theoretical edifice on which such observations are based. Others advocate greater theoretical flexibility (Gabbard 1996, 2007; Pine 1990; Pulver 1992), suggesting that different patients and different types of psychopathology require different theoretical approaches.

Each of these approaches to the theoretical pluralism of modern dynamic psychiatry is workable for some clinicians. Regardless of which approach is found to be more suitable, all clinicians should be wary of rigidly imposing theory onto clinical material. The patient must be allowed to lead the clinician into whatever theoretical realm appears to be the best match for the clinical material. Another possibility, of course, is that the material leads to uncharted terrain where no theoretical model is particularly useful. Clinicians may have to improvise and stay close to the clinical material without benefit of a theoretical edifice on which to stand. Open-mindedness is of paramount importance in this regard.

Clinicians must always remember that theory is metaphor. Our theories attempt to capture what human psychology is like, but because they are metaphors, they must suffer the fate of all metaphors: at some point they break down (Gabbard 2007). The best we can do is to use theories as a tool in help-

ing us grasp what is going on inside the patient, knowing that a good deal of trial and error may be necessary. We also must be prepared for the possibility that we will be stumbling through a cave for a period of time without knowing the path that lies before us. Nevertheless, we may still be far better off than the traveler with a map of an altogether different cave.

References

Ainsworth MS, Blehar MC, Waters E, et al: Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ, Lawrence Erlbaum, 1978

Allen JG: Mentalizing in the Development and Treatment of Attachment Trauma. London, Karnac, 2013

Allen JG, Deering CD, Buskirk JR, et al: Assessment of therapeutic alliances in the psychiatric hospital milieu. Psychiatry 51:291–299, 1988

Aron L: A Meeting of Minds: Mutuality and Psychoanalysis. Hillsdale, NJ, Analytic Press, 1996

Bacal HA: Optimal responsiveness and the therapeutic process, in Progress in Self Psychology, Vol 1. Edited by Goldberg A. New York, Guilford, 1985, pp 202–227

Bacal HA: British object-relations theorists and self psychology: some critical reflections. Int J Psychoanal 68:81–98, 1987

Bacal HA, Newman KM: Theories of Object Relations: Bridges to Self Psychology. New York, Columbia University Press, 1990

Baker HS, Baker MN: Heinz Kohut's self psychology: an overview. Am J Psychiatry 144: 1–9, 1987

Balint M: The Basic Fault: Therapeutic Aspects of Regression. New York, Brunner/Mazel, 1979

Bass A: When the frame doesn't fit the picture. Psychoanal Dialogues 17:1–27, 2007

Beebe B, Lachmann F, Jaffe J: Mother–infant interaction structures and presymbolic self and object representations. Psychoanalytic Dialogues 7:133–182, 1997

Bellak L, Hurvich M, Gedimen HK: Ego Functions in Schizophrenics, Neurotics, and Normals: A Systematic Study of Conceptual, Diagnostic, and Therapeutic Aspects. New York, Wiley, 1973

Benjamin J: An outline of intersubjectivity: the development of recognition. Psychoanalytic Psychology 7(suppl):33–46, 1990

Bion WR: Learning From Experience. New York, Basic Books, 1962

Bollas C: The Shadow of the Object: Psychoanalysis of the Unthought Known. New York, Columbia University Press, 1987

Bollas C: Forces of Destiny: Psychoanalysis and Human Idiom. Northvale, NJ, Jason Aronson, 1989

Boston Change Process Study Group: Change in Psychotherapy: A Unifying Paradigm. New York, WW Norton, 2010

Bowlby J: Attachment and Loss, Vol 1: Attachment. London, Hogarth Press/Institute of Psycho-Analysis, 1969

Bowlby J: Attachment and Loss, Vol 2: Separation: Anxiety and Anger. London, Hogarth Press/Institute of Psycho-Analysis, 1973

Bowlby J: Attachment and Loss, Vol 3: Loss: Sadness and Depression. London, Hogarth Press/Institute of Psycho-Analysis, 1980

Brenner C: The Mind in Conflict. New York, International Universities Press, 1982

Bromberg PM: Awakening the Dreamer: Clinical Journeys. Hillside, NJ, Analytic Press, 2006

Calarge C, Andreasen NC, O'Leary DS: Visualizing how one brain understands another: a PET study of theory of mind. Am J Psychiatry 160:1954–1964, 2003

Chodorow NJ: Theoretical gender and clinical gender: epistemological reflections on the psychology of women. J Am Psychoanal Assoc 44(suppl):215–238, 1996

Chodorow NJ: Individualizing Gender and Sexuality: Theory and Practice. New York, Routledge, 2012

Coburn WJ: Self psychology after Kohut—one theory or too many? Int J Psychoanal Self Psychol 1:1–4, 2006

Curtis HC: Clinical perspectives on self psychology. Psychoanal Q 54:339–378, 1985

Dunn J: Intersubjectivity in psychoanalysis: a critical review. Int J Psychoanal 76:723–738, 1995

Eagle MN: Recent Developments in Psychoanalysis: A Critical Evaluation. New York, McGraw-Hill, 1984

Eagle M: The concepts of need and wish in self psychology. Psychoanalytic Psychology 7(suppl):71–88, 1990

Erikson EH: Identity and the life cycle: selected papers. Psychol Issues 1:1–171, 1959

Fairbairn WRD: Schizoid factors in the personality (1940), in Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952, pp 3–27

Fairbairn WRD: Endopsychic structure considered in terms of object-relationships (1944), in Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952, pp 82–136

Fairbairn WRD: Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952

Fairbairn WRD: Synopsis of an object-relations theory of the personality. Int J Psychoanal 44:224–225, 1963

Feldman M: Projective identification: the analyst's involvement. Int J Psychoanal 78: 227–241, 1997

Fogassi L, Gallese V: The neurocorrelates of action understanding in nonhuman primates, in Mirror Neurons and the Evolution of Brain and Language. Edited by Stanemov MI, Gallese V. Amsterdam, John Benjamin's Publishing, 2002, pp 13–36

Fogel A: Movement and communication in human infancy: the social dynamics of development. Hum Mov Sci 11:387–423, 1992

Fonagy P: An attachment theory approach to treatment of the difficult patient. Bull Menninger Clin 62:147–169, 1998

Fonagy P: Attachment Theory and Psychoanalysis. New York, Other Press, 2001

Fonagy P, Target M: Psychoanalytic Theories: Perspectives From Developmental Psychology. London, Whurr Publishers, 2003

Frenkel RS: A reconsideration of object choice in women: phallus or fallacy. J Am Psychoanal Assoc 44(suppl):133–156, 1996

Freud A: The ego and the mechanisms of defense (1936), in The Writings of Anna Freud, Vol 2, Revised Edition. New York, International Universities Press, 1966

Freud S: Three essays on the theory of sexuality (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 123–245

Freud S: Inhibitions, symptoms and anxiety (1926), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 20. Translated and edited by Strachey J. London, Hogarth Press, 1959, pp 75–175

Freud S: The ego and the id (1923), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 19. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 1–66

Freud S: Some psychical consequences of the anatomical distinction between the sexes (1925), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 19. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 241–258

Freud S: Fetishism (1927), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 21. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 147–157

Freud S: Female sexuality (1931), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 21. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 223–243

Freud S: On narcissism: an introduction (1914), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 67–102

Freud S: Mourning and melancholia (1917), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 237–260

Freud S: Femininity (1933), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 22. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 112–135

Freud S: Analysis terminable and interminable (1937), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 23. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 209–253

Freud S: Splitting of the ego in the process of defence (1940), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 23. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 271–278

Friedman RC, Downey JI: Sexual differentiation of behavior. J Am Psychoanal Assoc 56:147–175, 2008

Frith U, Frith CD: Development and neurophysiology of mentalizing. Philos Trans R Soc Lond B Biol Sci 358:459–473, 2003

Gabbard GO: Countertransference: the emerging common ground. Int J Psychoanal 76:475–485, 1995

Gabbard GO: Love and Hate in the Analytic Setting. New York, Jason Aronson, 1996

Gabbard GO: A reconsideration of objectivity in the analyst. Int J Psychoanal 78:15–26, 1997

Gabbard GO: "Bound in a nutshell": thoughts on complexity, reductionism, and "infinite space." Int J Psychoanal 88:559–574, 2007

George C, Solomon J: The caregiving system: behavioral systems approach to parenting, in Handbook of Attachment: Theory, Research and Clinical Applications, 2nd Edition. Edited by Cassidy J, Shaver, PR. New York, Guilford Press, 2008, pp 833–856

George C, Kaplan N, Main M: The Adult Attachment Interview. Department of Psychology, University of California, Berkeley, 1996

Gill MM: Psychoanalysis in Transition: A Personal View. Hillsdale, NJ, Analytic Press, 1994

Greenberg J: Oedipus and Beyond: A Clinical Theory. Cambridge, MA, Harvard University Press, 1991

Greenberg J, Mitchell SA: Object Relations in Psychoanalytic Theory. Cambridge, MA, Harvard University Press, 1983

Grinberg L: Countertransference and projective counteridentification, in Countertransference. Edited by Epstein L, Feiner A. New York, Jason Aronson, 1979, pp 169–191

Grotstein JS: Splitting and Projective Identification. New York, Jason Aronson, 1981

Guntrip H: Schizoid Phenomena, Object-Relations, and the Self. New York, International Universities Press, 1968

Guntrip H: Psychoanalytic Theory, Therapy, and the Self. New York, Basic Books, 1971

Harris AE: The relational tradition: landscape and canon. J Am Psychoanal Assoc 59:701–735, 2011

Hartmann H: Ego Psychology and the Problem of Adaptation (1939). Translated by Rapaport D. New York, International Universities Press, 1958

Hofer MA: Developmental psychobiology of early attachment. In Developmental Psychobiology. Edited by Casey BJ. Washington, DC, American Psychiatric Publishing, 2004, pp 1–28

Hoffman IZ: Some practical implications of a social constructivist view of the psychoanalytic situation. Psychoanalytic Dialogues 2:287–304, 1992

Hoffman IZ: Ritual and Spontaneity in the Psychoanalytic Process: A Dialectical-Constructivist View. Hillsdale, NJ, Analytic Press, 1998

Jacobson E: The Self and the Object World. New York, International Universities Press, 1964

Joseph B: Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph. Edited by Feldman M, Spillius EB. London, Routledge, 1989

Kernberg OF: Borderline personality organization. J Am Psychoanal Assoc 15:641–685, 1967

Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Kernberg OF: Self, ego, affects, and drives. J Am Psychoanal Assoc 30:893–917, 1982

Kernberg OF: Object relations theory and character analysis. J Am Psychoanal Assoc 31(suppl):247–272, 1983

Kernberg OF: Concluding discussion, in Projection, Identification, Projective Identification. Edited by Sandler J. Madison, CT, International Universities Press, 1987, pp 179–196

King P, Steiner R: The Freud-Klein Controversies 1941–45. London, Routledge, 1992

Klein M: Notes on some schizoid mechanisms (1946), in Envy and Gratitude and Other Works, 1946–1963. New York, Free Press, 1975, pp 1–24

Kohon G: The British School of Psychoanalysis: The Independent Tradition. New Haven, CT, Yale University Press, 1986

Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971

Kohut H: The Restoration of the Self. New York, International Universities Press, 1977

Kohut H: How Does Analysis Cure? Edited by Goldberg A. Chicago, IL, University of Chicago Press, 1984

Lerner HE: Penis envy: alternatives in conceptualization. Bull Menninger Clin 44: 39–48, 1980

Leslie KR, Johnson-Frey SH, Grafton ST: Functional imaging of face and hand imitation: towards a motor theory of empathy. Neuroimage 21:601–607, 2004

Levine HB: The analyst's participation in the analytic process. Int J Psychoanal 75:665–676, 1994

Levine HB: The analyst's infatuation: reflections on an instance of countertransference love. Paper presented at the annual meeting of the American Psychoanalytic Association, New York, NY, December 1996

Lichtenberg JD: Experience as a guide to psychoanalytic theory and practice. J Am Psychoanal Assoc 46:17–36, 1998

Lichtenberg JD, Hadley JL: Psychoanalysis and Motivation. Hillsdale, NJ, Analytic Press, 1989

Lindon JA: Gratification and provision in psychoanalysis: should we get rid of the "rule of abstinence?" Psychoanalytic Dialogues 4:549–582, 1994

Mahler MS, Pine F, Bergman A: The Psychological Birth of the Human Infant: Symbiosis and Individuation. New York, Basic Books, 1975

McClure EB: A meta-analysis review of sex differences in facial expression processing and their development in infants, children, and adolescents. Psychol Bull 126:423–453, 2000

Meins E, Ferryhough C, Fradley E, et al: Rethinking maternal sensitivity: mothers' comments on infants' mental processes predict security of attachment at 12 months. J Child Psychol Psychiatry 42:637–648, 2001

Meissner WW: Can psychoanalysis find its self? J Am Psychoanal Assoc 34:379–400, 1986

Mitchell SA: Contemporary perspectives on self: toward an integration. Psychoanalytic Dialogues 1:121–147, 1991

Mitchell SA: Hope and Dread in Psychoanalysis. New York, Basic Books, 1993

Mitchell SA: Influence and Autonomy in Psychoanalysis. Hillsdale, NJ, Analytic Press, 1997

Moore DS, Cocas LA: Perception precedes computation: can familiarity preferences explain apparent calculation by human babies? Dev Psychol 42:666–678, 2006

Natterson JM: Beyond Countertransference: The Therapist's Subjectivity in the Therapeutic Process. Northvale, NJ, Jason Aronson, 1991

Ogden TH: On projective identification. Int J Psychoanal 60:357–373, 1979

Ogden TH: The concept of internal object relations. Int J Psychoanal 64:227–241, 1983

Ogden TH: The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue. Northvale, NJ, Jason Aronson, 1986

Ogden TH: The Primitive Edge of Experience. Northvale, NJ, Jason Aronson, 1989

Ogden TH: The dialectically constituted/decentred subject of psychoanalysis, II: the contributions of Klein and Winnicott. Int J Psychoanal 73:613–626, 1992

Ornstein PH: On narcissism: beyond the introduction, highlights of Heinz Kohut's contributions to the psychoanalytic treatment of narcissistic personality disorders. Annual of Psychoanalysis 2:127–149, 1974

Perry JC, Cooper SH: A preliminary report on defenses and conflicts associated with borderline personality disorder. J Am Psychoanal Assoc 34:863–893, 1986

Pine F: The four psychologies of psychoanalysis and their place in clinical work. J Am Psychoanal Assoc 36:571–596, 1988

Pine F: Drive, Ego, Object, and Self: A Synthesis for Clinical Work. New York, Basic Books, 1990

Pizer SA: Impasse recollected and tranquility: love, dissociation, and discipline in clinical dyads. Psychoanal Dialogues 14:289–311, 2004

Posner MI, Rothbart MK: Developing mechanisms of self-regulation. Dev Psychopathol 12:427–441, 2000

Pulver SE: Psychic change: insight or relationship? Int J Psychoanal 73:199–208, 1992

Rangell L: The self in psychoanalytic theory. J Am Psychoanal Assoc 30:863–891, 1982

Rapaport D: Organization and Pathology of Thought: Selected Sources. New York, Columbia University Press, 1951

Reiss D, Neiderhiser J, Hetherington EM, et al: The Relationship Code: Deciphering Genetic and Social Patterns in Adolescent Development. Cambridge, MA, Harvard University Press, 2000

Renik O: Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. Psychoanal Q 62:553–571, 1993

Renik O: The analyst's subjectivity and the analyst's objectivity. Int J Psychoanal 79: 487–497, 1998

Ringstrom P: Scenes that write themselves: improvisational moments in relational psychoanalysis. Psychoanal Dialogues 17:69–99, 2007

Rinsley DB: An object relations view of borderline personality, in Borderline Personality Disorders. Edited by Hartocollis P. New York, International Universities Press, 1977, pp 47–70

Sandler J: On internal object relations. J Am Psychoanal Assoc 38:859–880, 1990

Sandler J: On attachment to internal objects. Psychoanalytic Inquiry 23:12–26, 2003

Sandler J, Rosenblatt B: The concept of the representational world. Psychoanal Study Child 17:128–145, 1962

Schafer R: Aspects of Internalization. New York, International Universities Press, 1968

Schafer R: A New Language for Psychoanalysis. New Haven, CT, Yale University Press, 1976

Schafer R: Narratives of the self, in Psychoanalysis: Toward the Second Century. Edited by Cooper AM, Kernberg OF, Person ES. New Haven, CT, Yale University Press, 1989, pp 153–167

Schore AN: A century after Freud's project: is a rapprochement between psychoanalysis and neurobiology at hand? J Am Psychoanal Assoc 45:807–840, 1997

Sebanz N, Frith C: Beyond simulation? Neuromechanisms for predicting the actions of others. Nat Neurosci 7:5–6, 2004

Segal H: An Introduction to the Work of Melanie Klein. New York, Basic Books, 1964

Siegel A: Heinz Kohut and the Psychology of Self. London, Routledge, 1996

Silverman DK: Our sexy brain; our compelling environment: interactionism in female development. Psychoanal Rev 97:1–19, 2010

Silverstein ML: Disorders of the Self: A Personality-Guided Approach. American Psychological Association, Washington, DC, 2007

Spillius EB: Clinical experiences of projective identification, in Clinical Lectures on Klein and Bion. Edited by Anderson R. London, Tavistock/Routledge, 1992, pp 59–73

Stern DN: The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology. New York, Basic Books, 1985

Stern DN: Developmental prerequisites for the sense of a narrated self, in Psychoanalysis: Toward the Second Century. Edited by Cooper AM, Kernberg OF, Person ES. New Haven, CT, Yale University Press, 1989, pp 168–178

Stern DN: The Present Moment in Psychotherapy and Everyday Life. New York, WW Norton, 2004

Stoller RJ: Primary femininity. J Am Psychoanal Assoc 24(suppl):59–78, 1976

Stolorow RD, Brandchaft B, Atwood GE: Psychoanalytic Treatment: An Intersubjective Approach. Hillsdale, NJ, Analytic Press, 1987

Summers FL: Transcending the Self: An Object Relations Model of Psychoanalytic Therapy. Hillsdale, NJ, Analytic Press, 1999

Sutherland JD: The British object relations theorists: Balint, Winnicott, Fairbairn, Guntrip. J Am Psychoanal Assoc 28:829–860, 1980

Sutherland JD: The self and object relations: a challenge to psychoanalysis. Bull Menninger Clin 47:525–541, 1983

Torok M: The significance of penis envy in women, in Female Sexuality: New Psychoanalytic Views. Edited by Chasseguet-Smirgel J. Ann Arbor, University of Michigan Press, 1970, pp 135–170

Tuckett D: Editorial introduction to "My Experience of Analysis With Fairbairn and Winnicott" by Guntrip H. Int J Psychoanal 77:739–740, 1996

Tyson P: Female psychology: an introduction. J Am Psychoanal Assoc 44(suppl):11–20, 1996

Vaillant GE: Natural history of male psychological health, V: the relation of choice of ego mechanisms of defense to adult adjustment. Arch Gen Psychiatry 33:535–545, 1976

Vaillant GE: Adaptation to Life. Boston, MA, Little, Brown, 1977

Wallerstein RS: One psychoanalysis or many? Int J Psychoanal 69:5–21, 1988

Westen D, Nakash O, Thomas C, et al: Clinical assessment of attachment patterns and personality disorder in adolescents and adults. J Consult Clin Psychol 74:1065–1085, 2006

Winnicott DW: The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. London, Hogarth Press, 1965

Winnicott DW: Transitional objects and transitional phenomena: a study of the first not-me possession (1953), in Playing and Reality. New York, Basic Books, 1971, pp 1–25

Wolf E: Treating the Self: Elements of Clinical Self Psychology. New York, Guilford, 1988

CHAPTER 3

PSYCHODYNAMIC ASSESSMENT OF THE PATIENT

> Whenever two people meet there are really six people present. There is each man as he sees himself, each man as the other person sees him, and each man as he really is.
>
> *William James*

The psychodynamic assessment of a patient does not stand apart from the thorough evaluation of history, signs, and symptoms growing out of the medical-psychiatric tradition. Dynamic psychiatrists value such information as a crucial component of the diagnostic assessment. However, their approach to gathering that information differs from the purely descriptive approach to diagnosis. Moreover, other information is of interest to the dynamic psychiatrist, so the psychodynamic assessment may be viewed as a significant extension of the descriptive medical-psychiatric evaluation.

The Clinical Interview

Any description of the psychodynamic approach to clinical interviewing must begin with the fundamental importance of the doctor–patient relation-

ship. When psychiatrist and patient meet for the first time, two strangers are coming into contact, each with a variety of expectations concerning the other. Establishing rapport and a shared understanding must always be the first agenda in a psychodynamic interview (MacKinnon et al. 2006; Menninger et al. 1962; Thomä and Kächele 1987). The first task of the interviewer, then, is to convey that the patient is accepted, valued, and validated as a unique person with unique problems.

Interviewers who attempt to immerse themselves empathically in their patients' experience will promote a bond between them based on the interviewer's obvious attempt to understand the patient's point of view. Such an approach does not require reassuring comments such as "Don't worry, everything will be all right." Rather than allaying the patient's anxiety, these hollow reassurances are usually doomed to failure because they resemble similar past comments of friends and family members. They will only lead the patient to believe that the interviewer does not appreciate true suffering. Interviewers may instead build better rapport with comments such as "I can understand how you feel, considering what you've been through." Challenging a patient's statements early in the interview will simply confirm any preexisting fears that psychiatrists are judgmental parental figures.

Differences Between Psychodynamic and Medical Interviewing

In medical interviewing, physicians pursue a direct course from the chief complaint to its etiology and pathogenesis. Patients generally cooperate with this process because they are eager to eliminate the pain or symptoms associated with their illness. Psychiatrists who attempt to steer a similarly linear course in the clinical interview will encounter potholes and detours at every turn. Moreover, psychiatrists find that patients rarely are capable of coming quickly to the point because of their inability to pinpoint what is really bothering them (Menninger et al. 1962). They may also be highly ambivalent about giving up their symptoms because psychiatric illness is somehow always a workable adaptation. Finally, psychiatric patients are often embarrassed about their symptoms and may conceal information to make a good impression (MacKinnon et al. 2006).

Another major difference between medical history taking and psychodynamic interviewing is the interrelationship of diagnosis and treatment. A physician evaluating a patient for appendicitis approaches the interview with a clear mind-set—diagnosis precedes treatment. In the psychodynamic interview, however, any distinction between diagnosis and treatment would be artificial (MacKinnon et al. 2006). The dynamic psychiatrist approaches the interview with the understanding that the manner in which the history is taken may in and of itself be therapeutic. The dynamic view, which inti-

mately links diagnosis and treatment, is empathic in the sense that it takes into account the patient's perspective. As Menninger et al. (1962) noted: "The patient comes to be treated and everything that is done for him, so far as he is concerned, is treatment, whatever the doctor may call it. In a sense, therefore, treatment always precedes diagnosis" (p. 3). Indeed, there is undoubtedly some therapeutic action in listening and accepting the patient's life story and validating that the patient's life has meaning and value (Gabbard 2010). The clinician evaluating a patient is also serving as a witness who is recognizing and grasping the emotional impact of what has happened to the patient (Poland 2000).

A third distinction between medical and psychodynamic interviewing lies in the dimensions of activity and passivity. To a large extent patients are passive participants in the medical diagnostic process. The patient complies with the physician's evaluation by cooperatively answering questions. The physician, however, must fit together the pieces of the diagnostic puzzle to arrive at a definitive diagnosis. The dynamic psychiatrist tries to avoid this division of roles. Instead, the dynamic approach involves actively engaging the patient as a collaborator in an exploratory process (Shevrin and Shectman 1973). The patient is viewed as someone with a great deal to contribute to the ultimate diagnostic understanding. If a patient begins an interview with anxiety, the psychiatrist does not try to eliminate it to facilitate the interview. On the contrary, the psychiatrist might attempt to engage the patient in a collaborative search for the origins of the anxiety with such questions as: "What concerns about this interview might cause you to be anxious right now?" "Does this situation remind you of any similar anxiety-provoking situations in the past?" or "Have you heard anything about me or about psychiatrists in general that might contribute to your anxiety?"

In a productive dynamic interview, the psychiatrist will elicit information regarding symptoms and history that allows for a descriptive diagnosis. To promote more openness on the part of the patient, however, psychiatrists must guard against an overemphasis on diagnostic labeling that precludes the unfolding of the complex relationship between doctor and patient. MacKinnon et al. (2006) warned that "the interview that is oriented only toward establishing a diagnosis gives the patient the feeling that he is a specimen of pathology being examined, and therefore actually inhibits him from revealing his problems" (p. 6).

A fourth difference between the medical and the dynamic orientation in clinical interviewing revolves around the selection of relevant data. Reiser (1988) expressed alarm at the tendency of some psychiatric residents to stop data collection after eliciting a symptom inventory that satisfies a descriptive diagnostic category and that allows for pharmacotherapeutic prescription. He warned that a DSM diagnosis is only one aspect of the diagnostic process

and that the residents' lack of interest in understanding the patient as a person forms an obstacle to establishing a therapeutic relationship. For dynamic psychiatrists, the intrapsychic life of the patient is a crucial part of the data pool.

Another unique aspect of the psychodynamic interview is the emphasis on the doctor's feelings during the process. The surgeon or internist who notes feelings of anger, envy, lust, sadness, hatred, or admiration views these feelings as annoyances that interfere with evaluating the illness. The typical physician suppresses these feelings in the service of maintaining objectivity and proceeding with the examination. For the dynamic psychiatrist, such feelings constitute crucial diagnostic information. They tell the clinician something about what reactions the patient elicits in others. These considerations lead us directly to two of the most important aspects of the psychodynamic assessment—transference and countertransference.

The final difference between medical history taking and psychodynamic interviewing is one of pace. In the typical medical interview, the physician is attempting to obtain as much information as quickly as possible to make a decision on diagnosis and treatment and to move on to the next patient in the waiting room. The psychodynamic interviewer, however, should not feel rushed. Psychodynamic clinicians slow things down to create a climate in which the patient can reflect, pause, feel whatever he or she is feeling, and put things together (Peebles 2012). This approach to time conveys a powerful message to the patient: everything will not be understood in one meeting but will ultimately unfold over a period of time. The psychiatric resident may have learned history taking in an emergency department or an inpatient unit where the pace is entirely different. It may take a period of adjustment before residents recognize that they cannot possibly obtain all the information they need for a thorough psychodynamic understanding of the patient. They will simply develop a notion of the key themes that haunt the patient and that have led the patient to come for help. These initial themes may change shape in some ways over time, but they provide a place to start.

Transference and Countertransference

Given the fact that transference is active in every significant relationship, you can be certain that transference elements exist from the first encounter between doctor and patient. Indeed, transference may even develop before the initial contact (Thomä and Kächele 1987). After making the first appointment, the soon-to-be patient may begin attributing qualities to the psychiatrist based on bits of factual information, previous experiences with psychiatrists, media portrayals of psychiatrists, positive or negative experiences with other physicians in the past, or general attitudes toward authority

figures. One young man who first met his psychiatrist in the waiting room exclaimed, "Why, you're not at all like I expected you to be!" When the psychiatrist asked the patient to elaborate, the young man explained that the psychiatrist's name evoked images of a distinguished elderly man, and he was shocked at the youth of the actual psychiatrist.

Transference is a critical dimension of the evaluation because it profoundly affects the patient's cooperation with the doctor. Patients who view doctors as stern, disapproving parents, for example, will be much less forthcoming with embarrassing aspects of their history. Likewise, patients who view psychiatrists as intrusive busybodies may stubbornly withhold information and refuse to cooperate in the interview. Psychiatrists who address the transference distortions early in the interview may remove obstacles to effective history taking.

During the first few minutes of a consultation with a psychiatrist, one patient was struggling to overcome his inhibitions about talking. The psychiatrist asked if any of his actions or comments made it difficult for the patient to talk. The patient confided that he had harbored the notion that psychiatrists were like mind readers and that he needed to be wary of what he did or said in their presence. The psychiatrist replied humorously, "I'm afraid we're not that good." Both laughed, and the patient found it much easier to open up during the rest of the interview.

By definition, transference is a repetition. The feelings associated with a figure from the past are being repeated with the psychiatrist in the present situation. This premise implies that transference patterns in a clinical interview provide glimpses of significant relationships from the patient's past. The patient's view of the examiner and the patient's feelings toward the examiner are somehow repetitions. Furthermore, these repetitions also reveal a good deal about the patient's current significant relationships. Because transference is ubiquitous, the same patterns from the past are repeated again and again in all the patient's relationships. For example, a woman patient came to a psychiatrist and complained that men seemed uninterested in her. In response to her psychiatrist's inquiries, she was able to link this feeling of being neglected with her childhood perception that her father ignored her. When the psychiatrist looked at his clock late in the interview, she accused him of not paying attention to her—just like all other men.

To keep from labeling all the patient's reactions to the doctor as transference, psychiatrists must keep in mind that the patient–doctor relationship is always a mixture of transference and a real relationship. The psychiatrist who glanced at his clock provided a kernel of reality to the patient's transference fear that yet another man was losing interest in her. Psychodynamic assessment requires continuous self-monitoring throughout the diagnostic process. The psychiatrist accused of being inattentive must question

whether he really is feeling boredom (and conveying it to the patient) or whether the patient is distorting the situation. If boredom is the problem, then the psychiatrist needs to determine whether his interest is waning because of interference from his own issues, or because the patient is doing something to evoke inattentiveness, or both.

These considerations are, of course, countertransference concerns. The conceptual framework of the dynamic interview is that it involves two persons (dare I say two patients?). Each brings a personal past into the present and projects aspects of internal self and object representations onto the other (Langs 1976). It is commonplace for dynamic psychiatrists to find themselves relating to a patient as though the patient were someone else. The psychiatrist might note a striking physical resemblance between a patient and someone from the past. As a result, the psychiatrist then attributes qualities of the past figure to the patient.

An ongoing task for dynamic psychiatrists is to monitor their own countertransference enactments and feelings as they emerge in the interview with the patient. How much of the countertransference is the clinician's own contribution? How much is induced by the patient's behavior toward the clinician? As I noted in Chapter 2, ordinarily countertransference is a joint creation that involves contributions from both members of the dyad. Making the distinction between the induced variety of countertransference and that brought to the situation by the clinician's own unconscious conflicts is often a challenging task. Because the ability to make this distinction depends greatly on familiarity with one's own internal world, most dynamic psychiatrists find a personal treatment experience (either psychoanalysis or psychotherapy) of enormous value in monitoring and understanding countertransference.

Familiarity with one's own typical responses is helpful in sorting out the relative contributions. One child psychiatrist, for example, observed that she could tell when she was dealing with a victim of child abuse because she would develop an irrational feeling of anger accompanied by an impulse to abuse the child. In other words, an internal abusing object in the child was projected onto the psychiatrist, who in turn became provoked by the child's obnoxious and provocative behavior to the point where she identified with what had been projected onto her. Awareness of those feelings helped her to understand the nature of the patient's internal object world and the typical problems in the patient's interpersonal relationships.

A common form of countertransference that may go unidentified is related to unconscious or conscious assumptions about the patient's race or ethnicity. All clinicians, no matter how committed they are to practicing in a bias-free atmosphere, live and work in societies where racial and ethnic stereotypes abound. These stereotypes may creep into a clinician's diagnostic understanding and may manifest themselves in subtle forms of enactments

with the patient (Leary 2000). For example, a psychiatric resident found herself speaking more slowly and using simple language with an Asian American patient until the patient interrupted her and said politely, "You don't have to speak so slowly. I was born here." Caucasian clinicians may also fail to appreciate the impact on identity and self-esteem that a lifetime of discriminatory practices inflict on a member of an ethnic minority group. Socially induced traumas may be mistakenly understood as problems of a purely intrapsychic nature. Moreover, "white privilege" may make white clinicians oblivious to the powerful impact of seemingly small slights, often referred to as *microtraumas,* in members of minority groups (Gabbard et al. 2012).

Approaches to History Taking

The history-taking aspect of the interview should involve two simultaneous goals: a descriptive diagnosis and a dynamic diagnosis. To accomplish these goals, the psychiatrist must maintain a flexible interviewing style that shifts from a structured pursuit of specific facts (e.g., about symptoms, family history, stressors, duration of illness) to an unstructured posture of listening to the natural ebb and flow of the patient's thought processes. Throughout both structured and unstructured portions of the history taking, the examiner makes a fine-tuned assessment of the patient–doctor interaction. Kernberg (1984) characterized one form of the dynamic interview—the structural interview—as a systematic movement from a symptom inventory to an active focus on defensive operations in the here-and-now relationship with the interviewer.

Initially the interviewer must simply create an atmosphere in which the patient feels free to talk. Beginning psychiatric residents commonly err in aggressively interrogating patients only to elicit history and symptoms. Another common error is the assumption of a pseudoanalytic attitude of abstinence, virtual silence, and passivity. Residents who may be warm and personable individuals suddenly become stiff, overly formal, and cold when they interview a patient. The interviewer will get much further by becoming an active participant in the relationship—by warmly and empathically seeking to understand the patient's point of view.

The psychiatrist can learn a great deal by allowing the patient to ramble freely for a while. Initial comments should be designed to facilitate this rambling (e.g., "Tell me more," "Please go on," "I can understand your feeling that way," or "That must have been upsetting"). The distinctiveness of the material produced by this type of free association is supported by evidence from neuroscience research. Andreasen et al. (1995) used positron emission tomography to study the difference between focused episodic memory, when one recalls past experiences, and random episodic memory, involving uncensored thinking about experience, akin to free association. They found

significant differences between the two types of memory and noted that the free-ranging mental activity associated with random episodic memory produced large activations in association cortex and reflected both active retrieval of past experiences and planning of future experiences. Hence the alternation between allowing rambling associations in the interview and focusing the patient on specific events may produce different kinds of mental activity and different types of useful information for the interviewer.

Besides eliciting essential historical and mental status data, interviewers can discern patterns of association that may reveal significant unconscious connections. The order in which events, memories, concerns, and other psychological issues are verbalized is seldom random. Mathematicians have long known that it is impossible for any individual to generate prolonged sequences of random numbers. Within a short time, the numbers will fall into meaningful patterns. The mind prefers order to chaos. So it is with the verbalizations of the patient. Deutsch and Murphy (1955) based their approach to interviewing—known as "associative anamnesis"—on this principle:

> The method…consists in recording not only what the patient said, but also how he gave the information. It is of consequence not only that the patient tells his complaints, but also in what phase of the interview, and in which connection he introduces his ideas, complaints, and recollections of his somatic and emotional disturbances. (p. 19)

Although patients may be consciously baffled by their symptoms, the ordering of their associations may provide clues to unconscious connections. For example, a 31-year-old man who came with his parents for a psychiatric evaluation began the morning with a psychiatrist while his parents met privately with a social worker in a different building. The young man began by explaining that he had been unable to keep a job. He suddenly became overwhelmed with anxiety because he was uncertain of his parents' whereabouts. The psychiatrist clarified that they were with the social worker in the office building next door. The patient asked if he could use the psychiatrist's phone to call them. The psychiatrist silently noted that the patient's anxiety about his parents' location followed immediately on the heels of his complaint of not being able to hold a job. He asked the patient if the two concerns were connected. After a moment's reflection, the patient acknowledged that when he was away from his parents, at work, he worried that something would happen to them. This interchange led to a productive discussion about the patient's concerns that his growing up and becoming independent would be destructive to his parents.

Because of the central role of developmental theory in dynamic psychiatry, a developmental history must be part of a thorough dynamic assessment. Was the patient a product of an unwanted pregnancy? Did the patient's birth

occur after an older sibling had died? Did the patient achieve developmental milestones such as talking, walking, and sitting up at the appropriate ages? Were there traumatic separations or losses during the formative years? Obtaining such invaluable information often necessitates interviews of parents and other family members—either by the psychiatrist or by a social worker associated with the psychiatrist. Obviously, patients will be unable to recall some significant events of childhood and will distort others.

Despite their imperfect memories for historical events, patients should nevertheless be engaged in a review of childhood and adolescent development. A fundamental principle of the dynamic interview is that the past is repeating itself in the present. To enlist the patient as a collaborator in the diagnostic process, the interviewer can encourage the patient's curiosity about links between historical events and present-day feelings. A variety of open-ended questions serve to establish this collaborative partnership: "Does the anxiety you're experiencing today remind you of feelings you've had at any time in your past?" "Were there any events in your childhood that may have contributed to your feeling as an adult that women cannot be trusted?" "Do your current marital problems have any similarities with problems you've had in other relationships in the past?" As the patient begins to collaborate in the search for links between past and present, the examiner should note particular historical events and periods that seem important to the patient. Similarly, conspicuous omissions from the developmental history are also noteworthy. Does the patient, for example, focus exclusively on one parent as the cause of all current problems while omitting any reference to the other parent? What about the patient's cultural and religious background? How do these factors affect family relationships and the acceptability of emotional problems?

After several minutes of open-ended questions designed to facilitate a free-flowing history of the present illness and family and developmental issues, the psychiatrist can then fill in the gaps with more specific, direct questions. These may be geared to the descriptive diagnosis (e.g., specific symptoms necessary for the DSM-5 [American Psychiatric Association 2013] diagnosis, information about the duration of the illness, exclusions of other illnesses) or may be directed toward a more complete dynamic diagnosis (e.g., specific developmental traumas, relationship patterns, or recurrent fantasies and daydreams). As the patient fills in the gaps, the dynamic psychiatrist can begin to formulate hypotheses that link the patient's past relationships with current relationships and with emerging transference paradigms (Menninger 1958). In other words, how are repetitions of past relationship patterns creating problems in the present?

Patients can provide important dynamic information about their perception of the connections between events and symptoms. Again the examiner

should think in terms of how issues from the past are evoked by stressors in the present. One female executive developed extraordinary anxiety after receiving a promotion. She identified the promotion as the stressor but could not determine why it provoked anxiety, because she had sought the new job for several years. In the course of the interview, she frequently referred to her younger sister, who was divorced and supporting two children through a menial job. Further exploration of intense sibling rivalry that had existed between the sisters during childhood revealed that the executive's anxiety was related to guilt feelings. She was convinced that her promotion had been destructive to her sister. These feelings resonated with her childhood wish to triumph over her sister and be the only child in the eyes of their parents.

Holmes and Rahe (1967) developed a scale that ranks the severity of stress in a number of different life events. Although such scales can help provide consensual estimates of the effects that accompany particular life events, the dynamic psychiatrist must approach each patient as a unique individual and not assume *a priori* that a certain life event has only one specific meaning. For example, one young man reacted to his father's death with a liberated sense that he was finally free to pursue his career without incessant criticism. Hence, the stressor resulted in improved school performance and enhanced overall functioning.

In addition, the examiner should keep in mind that some stressors may operate at an unconscious level, preventing the patient from identifying any precipitating event when asked to do so. One function of the interview may be to work together to determine whether any stressors have been overlooked. Anniversary reactions, for example, are common stressors the patient may neglect. One chronically depressed patient became acutely suicidal on the anniversary of her brother's suicide. In another instance, when a happily married physician began having marital problems for no apparent reason, he called on a psychiatric colleague for advice. During the course of their phone conversation, the doctor suddenly realized that he was calling on the tenth anniversary of his divorce from his previous wife. This insight revealed that his current anger at his present wife was partially linked to his stormy relationship with his first wife.

Mental Status Examination

Like descriptive psychiatrists, dynamic psychiatrists are interested in mental status data, but they approach the information somewhat differently. First, to the extent that it is reasonable and possible, they prefer to weave mental status questions into the fabric of the interview rather than to add them at the end in a list of formal mental status questions (MacKinnon et al. 2006). Although some specific mental status questions should obviously be ap-

pended to the interview if they are not elicited during it, there is an advantage in minimizing the formal mental status examination. When these questions are brought into the body of the interview, the patient views distortions of perception, thought, and affect in a meaningful context. Moreover, in determining connections between such distortions and the illness, the patient becomes more involved as a collaborator rather than as merely a passive responder to questions.

Orientation and Perception

A patient's orientation to time, place, and person is often clear in the course of history taking. To ask specific orientation questions of someone who is obviously well oriented is likely to disturb the rapport of the doctor–patient relationship. Hyperalertness is a mental status finding that will also reveal itself without direct questioning. Significant perceptual symptoms such as auditory or visual hallucinations will often be evident at the beginning of the interview when the patient is asked to explain why psychiatric treatment is being sought. However, the dynamic psychiatrist is interested in more than the presence or absence of hallucinations. If a patient hears voices, the psychiatrist wants to know what the voices say, under what circumstances they speak, whose voices they sound like, and what the voices mean to the patient.

Cognition

The presence of a formal thought disorder will usually be clear from the history-taking portion of the interview. As alluded to earlier, even loose associations are connected idiosyncratically in the patient's mind. The examiner's task is to understand the nature of such connections. Delusions are also more likely to be elicited by open-ended historical questions than by specific questions about "false beliefs." The presence or absence of delusions is only part of the psychodynamic assessment; their meanings and functions are equally relevant. The grandiose delusions of the paranoid patient may serve to compensate for devastating feelings of low self-esteem.

Because cognition affects language and communication, the psychiatrist must also listen for parapraxes, or slips of the tongue, that reveal glimpses of the unconscious at work. A pregnant woman whose obstetrician referred her for a psychiatric consultation was resentful about seeing a psychiatrist, and at one point she exclaimed, "I don't want to be a psychiatric parent—I mean patient!" The examining psychiatrist could conclude from this parapraxis that the patient was highly ambivalent about becoming a mother.

The patient's manner of answering questions may reveal a good deal about his or her unconscious character style. The obsessive-compulsive patient may respond to questions with an overinclusive attention to detail,

frequently asking the examiner to elaborate on specifically requested information. By contrast, the passive-aggressive patient may produce anger in the interviewer by asking for questions to be repeated and by generally thwarting attempts to elicit historical data. The paranoid patient may constantly read hidden meanings into the questions, thus placing the examiner on the defensive.

Determining the presence or absence of suicidal ideation is essential to any psychiatric evaluation. Suicidal patients should be asked outright if they have a suicide plan and if they have a support system of people they can talk to before acting impulsively. The psychodynamic assessment should discern the meaning of the contemplated suicide. Is there a reunion fantasy with a deceased loved one? Is suicide a vengeful act designed to devastate someone else just as that person once devastated the patient? Is suicide really designed to kill an internal object representation that is hated and feared? Of the many possible solutions to a patient's problems, why is suicide so compelling?

Affect

Observations about the patient's emotional states provide a gold mine of information about defense mechanisms. After all, the management of affect is one of the most important functions of defenses. Patients who describe extraordinarily painful events in their lives without being moved in the least may be employing isolation of affect. Hypomanic patients who assert that they always are in a good mood and are unusually jocular with the examiner may be using denial to defend against feelings such as grief and anger. Borderline patients who express contempt and hostility toward the key figures in their lives may be employing splitting to ward off any integration of good and bad feelings toward others. Mood, a subcategory of affect involving a sustained, internal feeling tone, should also be assessed. Exploration of moods with a patient often reveals that they are linked with significant self and object representations.

Action

A wealth of information is communicated through nonverbal behavior in the clinical interview. What particularly sensitive subjects result in the patient's fidgeting? What topics evoke silence? What issues cause the patient to break off eye contact with the examiner? Despite the fact that patients attempt to conceal essential data from the examining psychiatrist, their nonverbal behaviors will consistently betray them. Freud made the following observation in 1905:

> When I set myself the task of bringing to light what human beings keep hidden within them, not by the compelling power of hypnosis, but by observing

> what they say and what they show, I thought the task was a harder one than it really is. He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which it is quite possible to accomplish. (Freud 1905/1953, pp. 77–78)

As Freud implied, one of the "royal roads" to the observation of the unconscious is nonverbal behavior. Freud's observation has been systematized in the work of Paul Ekman (1985), who developed the Facial Action Coding System that categorizes some 10,000 facial expressions. Ekman learned that facial expressions were hard-wired into the brain and can erupt without any conscious awareness about 200 milliseconds after a stimulus. He was able to identify when someone was telling a lie by studying the microexpressions that lasted less than half a second as the person responded to questions. He also noted that hand movements, posture, speech patterns, and "distancing language" are also characteristic of lying. Although an ordinary psychodynamic interview is not in a forensic setting, in which determining truthfulness is essential, Ekman's findings alert all clinicians to study subtle shifts in facial expression, body posture, and style of speaking as a sign of important emotional themes that the patient wishes to conceal. Early attachment relationships are internalized and encoded as implicit memory (Amini et al. 1996; Gabbard 1997). What unfolds in the relationship to the therapist is the patient's habitual mode of object relatedness shaped by those early attachment relationships, and much of that mode of relatedness is nonverbal. Patients who, for example, are shy about making eye contact, deferential in their manner, restrictive in their uses of gesture, and hesitant in their speech patterns are telling the clinician a great deal about their unconscious, internalized object relations and the way they relate to others outside of the clinical interview.

Psychological Testing

Projective psychological tests, principally the Rorschach and the Thematic Apperception Test, may be extraordinarily useful adjuncts to the psychodynamic assessment. The Rorschach consists of 10 symmetrical inkblots that present ambiguous stimuli to the patient. In the face of this ambiguity, patients will reveal a great deal about themselves through their interpretations of the amorphous shapes within the inkblots. Highly sophisticated guides to Rorschach interpretations have systematized the responses according to a psychodynamic diagnostic understanding of the patient (Kwawer et al. 1980; Rapaport et al. 1968; Schafer 1954).

The Thematic Apperception Test operates on a similar principle. A series of drawings or woodcuts, portraying persons and situations of varying de-

grees of ambiguity, allows patients a good deal of latitude in interpretation. Patients are asked to invent a story to describe each picture. In making up these stories, patients project their own fantasies, wishes, and conflicts onto the pictures. Projective testing is especially useful for patients who are guarded and laconic in the psychiatric interview and therefore do not share their inner life freely with the psychiatrist. Many patients, however, will reveal so much about themselves in the course of the clinical interview that psychological testing is not necessary as an adjunct.

In addition to projective testing, standard psychological tests that measure personality traits may be of considerable usefulness as well. The Millon Clinical Multiaxial Inventory (Millon 1977), for example, now in its third iteration, is useful for identifying characteristic themes in the patient's personality that may reflect wishes, fears, and defenses.

Physical and Neurological Examination

For obvious reasons, the patient's physical and neurological status is as important to the dynamic psychiatrist as it is to the descriptive psychiatrist. "The head bone is connected to the neck bone," so whatever goes wrong in the body will affect the brain—and vice versa. If the assessment is taking place in a hospital setting, dynamic psychiatrists may or may not perform their own physical and neurological examinations. If the assessment is of an outpatient in a private office, most dynamic psychiatrists prefer that an internist or other physician do the physical. Regardless of who does it, exploring the meaning of the physical is usually beneficial—both in terms of transference issues and in terms of patients' fantasies about their body. In any case, neither a descriptive nor a dynamic assessment can be complete without these data.

Psychodynamic Diagnosis

At the completion of the psychodynamic assessment, the clinician should arrive at a descriptive diagnosis (based on DSM-5 criteria) and a psychodynamic diagnosis (based on an understanding of the patient and the illness). Although both diagnoses inform the treatment planning, the descriptive diagnosis is geared to the assignment of the correct label, whereas the psychodynamic diagnosis is viewed as a summary of understanding that goes beyond the label.

The descriptive diagnosis may assist clinicians in planning appropriate pharmacological interventions. The dynamic diagnosis may facilitate the cli-

nician's understanding of what the medication prescription means to the patient and whether compliance with the medication is likely to be a problem.

In this context, I want to emphasize that the usefulness of a dynamic diagnosis is not limited to patients whose prescribed treatment is dynamic psychotherapy. The therapeutic management of the patient's personality is an integral part of all psychiatric treatment that must always be considered in treatment planning (Perry et al. 1987).

A complete psychodynamic diagnosis also involves assessing the patient from one or more of the four major theoretical perspectives discussed in Chapter 2: ego psychology, object relations theory, self psychology, and attachment theory. There is a clear advantage for the psychodynamic interviewer to think about multiple theoretical models as the material in the session unfolds. When clinicians draw on multiple perspectives rather than a favored one or two, the patient is likely to benefit because richer and more complex treatment planning can be designed with the different models in mind (Peebles 2012). Moreover, within psychoanalytic and psychodynamic thinking today, pluralism is far more common, as we have learned that one theoretical system rarely has all the answers for all patients.

Characteristics of the Ego

A great deal can be learned about patients' overall ego strength from their work histories and their relationship patterns. Those who have been able to hold jobs and establish committed relationships for reasonably long periods are likely to have more resilient egos than those who have not.

The assessment of certain key ego functions (Bellak et al. 1973) can help psychiatrists understand a patient's strengths and weaknesses and thus enable them to prescribe the treatment program. How is the patient's reality testing? Is there an ability to distinguish what is internal from what is external, or is there a persistent pattern of delusional misperception? Is the patient's reality testing intact in structured situations but impaired in unstructured situations? What about the patient's impulse control? Is there sufficient ego to delay the discharge of impulses, or is the patient virtually driven by impulses to the point where there is danger to others or self? Judgment is another ego function that must be assessed. Can the patient adequately anticipate the consequences of actions?

In planning for the appropriate form of psychotherapy, psychiatrists should also determine the psychological mindedness of the patient. Does the patient see problems as having an internal origin, or are all difficulties externalized and blamed on others in the environment? Can the patient synthesize and integrate various bits of data and reflect on their connections to develop meaningful explanations for symptoms and interpersonal difficul-

ties? Does the patient think in metaphors and analogies that allow for connections between various levels of abstraction? All these considerations aid in assessing the extent of psychological mindedness.

A major portion of ego assessment focuses on the defensive functioning of the ego. In the psychoanalytic setting, Waelder (1960) developed a series of questions that addresses the defensive operations of the patient. These same questions could be adapted to the dynamic assessment: "What are the patient's desires? What does the patient (unconsciously) want? And of what is he afraid? …And when he is afraid, what does he do?" (pp. 182–183). Pine (1990) added additional questions to assess the relationship between drives and the ego's responses to the drives:

> What wish is being expressed? what is the relation of the wish to consciousness? what is the fantasy? and how does it reflect a compromise among wish and defense and reality? how was the wish being defended against? and how effective/adaptive is the defense? can the particular anxiety seen be traced to this or that wish, ineffectively defended against? and can the particular guilt seen be understood in terms of the operation of conscience in relation to this or that wish? (pp. 44–45)

Pine also suggested that one should assess character in a similar manner by looking at the patient's characteristic defensive styles that are expressed as ego-syntonic modes of function. One can also assess the defense mechanisms on the continuum of immaturity to maturity described in Chapter 2. The patient who is able to use suppression and humor in the midst of a difficult situation is showing much greater ego strength than the patient who resorts to splitting and projective identification in the same situation.

Determining the ego's relationship to the superego is another vital part of an ego psychological assessment. Is the superego a rigid and ruthless overseer of the ego, or is there a flexibility and harmony in the relationship of superego to ego? Does the patient espouse realistic ideals, or is the patient driven by unreachable and fantastic goals? Are there antisocial tendencies in the patient characterized by an absent or underdeveloped superego? The answers to these questions also provide clues about the patient's childhood experiences with parental figures, because the superego is an internalized representation of those figures.

Object Relations

As an end result of the psychodynamic assessment, the clinician has information about the patient's interpersonal relationships in three contexts: childhood relationships, the real and transferential aspects of the relationship between the patient and the examining clinician, and current rela-

tionships outside the doctor–patient relationship. The nature of these relationships provides the psychiatrist with a good deal of information about the patient's position in family and social systems. Still needed, however, is an assessment of how the patient's family relationships influence the development of the clinical picture that brings the patient to the psychiatrist. Does an adolescent patient's symptomatic picture reflect the parents' marital problems? In other words, is the patient serving as a "carrier" of illness for the entire family?

Information about the patient's interpersonal relationships also tells a great deal about the nature of the patient's internal object relations. Interviews of family members and significant others can help sort out the extent of distortion inherent in the patient's view of other relationships. Certain easily discernible patterns seem to cut across all relationships. For example, does the patient always seem to end up as a masochistic partner in a sadomasochistic bond? Is the patient always taking care of others who are less functional and more in need of caretaking? Pine (1990) developed a series of questions specifically targeted at object relations that can be mulled over by the clinician during the course of an interview:

> What old object relationship is being repeated? and which of the roles in the object relationship is the subject (the patient) enacting—his own or that of the other? or both? Is the patient behaving like the person he was? he wished to be in the parents' eyes? they wanted him to be? they were? he wished they were? And what early passive experiences are being repeated actively? (p. 47)

Determining the level of maturity of object relations is an integral part of this assessment. Does the patient experience others ambivalently as whole objects having both good and bad qualities? Alternatively, does the patient view others as either idealized (all good) or devalued (all bad)? Does the patient see others as need-gratifying part-objects who serve only one function for the patient rather than as separate persons with needs and concerns of their own? Finally, what about object constancy? Can the patient tolerate being apart from significant others by summoning up a soothing internal image of the person who is missed?

The Self

A thorough dynamic assessment must evaluate several aspects of the patient's self. In the broad framework of self psychology, psychiatrists should examine the durability and cohesiveness of the self. Is it prone to fragmentation in response to the smallest slight from a friend or colleague? Does the patient need to be in the spotlight continually to receive affirming responses

from selfobjects? The maturity of the patient's selfobjects should also be assessed. Are the patient's selfobject needs satisfied by a mutually gratifying relationship in the context of a long-term commitment?

In addition to self-esteem, the psychiatrist should also assess the patient's self-continuity. Is the patient much the same over time, regardless of external circumstances, or is there a generalized identity diffusion? As Horowitz (1997) stressed, without a sense of self-coherence and continuity, an individual is more likely to develop symptoms and explosive shifts in his or her state of mind. Horowitz also pointed out that self-coherence is more than interpersonal style—it includes integrity and virtues within one's character. Evidence for identity diffusion would indicate that different self representations, split off from one another, are constantly jockeying for dominance over the total personality. Different self representations would obviously arise in connection with different object representations that are highly influenced by the interpersonal context at a given moment. The boundaries of the self are also of interest. Can the patient clearly differentiate his or her own mental contents from those of others, or is there a general blurring of self–object boundaries? Are the patient's body boundaries intact? Are mind and body viewed as connected over time, or are there episodes of depersonalization or out-of-body experience in which the mind seems independent of the body?

Attachment Patterns and Mentalization

The evaluating clinician listens to patterns of attachment and hopes to understand the patient's internal working models according to familiar categories of adult attachment: 1) secure/autonomous, 2) insecure/dismissing, 3) preoccupied, and 4) unresolved/disorganized (see Chapter 2). In a research setting, interviewers are likely to make use of the Adult Attachment Inventory, which is a semistructured interviewed composed of 15 questions that address the individual's experiences of parents or caregivers during childhood and their influence upon the individual as an adult (Gullestad 2003). In some respects, it is the adult equivalent of the Strange Situation (Stein et al. 1998). This instrument requires extensive training and a scoring manual. In the clinical setting, clinicians must simply listen for patterns and consider how the childhood experiences may contribute to adult relationships. In addition, they can assess to what extent the difficulties in early attachment may have promoted or impaired the capacity to mentalize. When children are securely attached, they develop the ability to understand people in terms of their feelings, desires, beliefs, and expectations (Fonagy 2001). In cases of trauma or neglect, children tend to shut down their thinking and dare not conceive of the parent's or caregiver's mind. This defensive reaction may impair the capacity to mentalize (Fonagy 2001).

Psychodynamic Formulation

The different elements enumerated in the previous discussion are the basis of a psychodynamic formulation. This tentative hypothesis or working model illustrates how the elements interact to create the clinical picture presented by the patient. Psychodynamic formulations must be embedded in a biopsychosocial context (Gabbard 2010). Three components form the foundation of a good formulation (Sperry et al. 1992). The formulation should begin with a sentence or two describing the clinical picture and the associated stressor or stressors precipitating the reason for seeking help. The second part of a formulation is developing a set of hypotheses about how biological, intrapsychic, and sociocultural factors contribute to the clinical picture. The third component is a brief statement about how the first two features of the formulation may inform the treatment and the prognosis.

Several underlying principles should be involved in the construction of a psychodynamic formulation. First, biological factors can be genetic or can be based on environmental influences, such as early trauma or head injury. Second, sociocultural factors may include family, religion, cultural practices, or even the impact of immigration. Some patients will appear more disturbed in a new culture than they might have in their home country. The loss of love objects, cultural values, native language, and original environment may lead to a "culture shock" phenomenon that severely compromises the immigrant's identity and self-esteem and precipitates a mourning process (Halperin 2004). Although the formulation is intended to explain the patient's condition, it does not have to explain everything. It should succinctly highlight the major issues, especially their relevance to treatment planning.

With some patients, one theoretical model will appear to have more explanatory value than the other two. With other patients, however, more than one theoretical perspective may seem useful in conceptualizing various aspects of the patient's psychopathology. As suggested in Chapter 1, clinicians should be open-minded to all the major theoretical frameworks and should embrace a "both/and" rather than an "either/or" attitude. The formulation should also be approached with the understanding that it undergoes continual modification as treatment proceeds. In dynamic psychiatry, diagnosis and treatment are always evolving together. A sample case history illustrates these points:

> Ms. A, a 33-year-old single woman employed as a librarian, came to the hospital in the midst of a psychotic episode with paranoid features. She had become convinced that her mother was plotting to kill her, and she had barricaded herself in the apartment she shared with her brother.
>
> When Ms. A reorganized after a few doses of an antipsychotic, she presented herself as a cheerful, Pollyanna-like person, commenting, "I have no

anger in me." She said she felt fine and wanted to go home. Her mother was glad to see her "back to normal" but expressed concern because Ms. A's brother was still at the apartment. He had apparently exploited his sister by moving in, eating her food, and living rent-free for the past several weeks.

According to her mother, Ms. A lived an isolated existence and had few interpersonal contacts outside several superficial relationships at work. Moreover, the patient's mother revealed that Ms. A had had one previous psychotic episode 18 months earlier when her brother had moved in with her under the same exploitative circumstances. Ms. A's mother also reported a family history of bipolar affective disorder.

The following psychodynamic formulation was developed: Ms. A inherited a diathesis toward bipolar affective disorder. Her cyclic psychotic episodes, which appeared schizophreniform, were possibly a variant of bipolar illness. After stabilizing the psychosis, the psychiatrist could consider prophylaxis with lithium or another mood stabilizer.

When Ms. A is nonpsychotic, her adjustment comes at the expense of massive denial of all negative feelings, especially anger, and results in a schizoid existence. The stressor of having her brother living parasitically in her apartment provoked so much anger in Ms. A that she could not maintain her usual defensive posture. Under pressure of this intense affect, she regressed to the paranoid-schizoid position, where an unacceptable self representation harboring angry, murderous feelings was split off and projected onto her mother. After remission of Ms. A's psychosis with medication, she reintrojected the self representation, which once again became buried under her denial.

The patient lacks the psychological mindedness to see any problems to work on in an exploratory therapy process. Casework or family therapy is therefore needed to remove the stressor (i.e., the brother) and to allow Ms. A to resume her previous adjustment with a follow-up regimen of medication and supportive psychotherapy to maintain her defenses and identify other potential stressors. We can anticipate further treatment compliance problems if her brother returns.

Although dynamic in its conceptualization, this formulation is in keeping with the biopsychosocial model of psychiatry championed by Engel (1977), Fink (1988), and others in that it takes into account genetic predisposition, social–familial influences, and intrapsychic factors.

Conclusion

Table 3–1 summarizes the steps involved in a thorough psychodynamic assessment. In the final analysis, the purpose of the assessment is to inform and guide the overall treatment planning. The case of Ms. A illustrates how a psychodynamic diagnosis, and particularly a psychodynamic formulation, can be useful even when dynamic psychotherapy is contraindicated. The treatment is nevertheless dynamically informed. The dynamic assessment

TABLE 3–1. Psychodynamic assessment

- Historical data
  - Present illness with attention to associative linkages and stressors
  - Past history with emphasis on how the past is repeating itself in the present
    - Developmental history
    - Family history
    - Cultural/religious background
- Mental status examination
  - Orientation and perception
  - Cognition
  - Affect
  - Action
- Projective psychological testing (if necessary)
- Physical and neurological examination
- Psychodynamic diagnosis
  - Descriptive DSM-5 diagnosis
  - Characteristics of the ego
    - Strengths and weaknesses
    - Defense mechanisms and conflicts
    - Relationship to superego
  - Quality of object relations
    - Family relationships
    - Transference–countertransference patterns
    - Inferences about internal object relations
  - Characteristics of the self
    - Self-esteem and self-cohesiveness
    - Self-continuity
    - Self-boundaries
    - Mind–body relationship
- Attachment patterns/mentalization capacity
- Psychodynamic formulation using above data

assists all aspects of treatment planning. An evaluation of ego functions can contribute to a decision regarding whether an individual should be an inpatient or an outpatient. For example, the extent of impulse control may be a crucial variable in deciding whether a patient should be admitted in the first place and, if so, when the patient can be discharged. A dynamic understanding of their patients can help clinicians decide whether their patients would accept a recommendation for sex therapy, behavior modification, family

therapy, or group therapy. Finally, each patient's compliance with any medication regimen will be affected by that particular patient's characterological substrate. The cases discussed in subsequent chapters illustrate how other theoretical models can be used in developing a formulation and how the dynamic assessment of the patient guides the treatment planning.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Amini F, Lewis T, Lannon R, et al: Affect, attachment, memory: contributions toward psychobiologic integration. Psychiatry 59:213–239, 1996

Andreasen NC, O'Leary DS, Cizadlo T, et al: Remembering the past: two facets of episodic memory explored with positron emission tomography. Am J Psychiatry 152:1576–1585, 1995

Bellak L, Hurvich M, Gedimen HK: Ego Functions in Schizophrenics, Neurotics, and Normals: A Systematic Study of Conceptual, Diagnostic, and Therapeutic Aspects. New York, Wiley, 1973

Deutsch F, Murphy WF: The Clinical Interview, Vol 1: Diagnosis: A Method of Teaching Associative Exploration. New York, International Universities Press, 1955

Ekman P: Telling Lies: Clues to Deceit in the Marketplace, Politics, and Marriage. New York, WW Norton, 1985

Engel GL: The need for a new medical model: a challenge for biomedicine. Science 196:129–136, 1977

Fink PJ: Response to the presidential address: is "biopsychosocial" the psychiatric shibboleth? Am J Psychiatry 145:1061–1067, 1988

Fonagy P: Attachment Theory and Psychoanalysis. New York, Other Press, 2001

Freud S: Fragment of an analysis of a case of hysteria (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 1–122

Gabbard GO: Challenges in the analysis of adult patients with histories of childhood sexual abuse. Canadian Journal of Psychoanalysis 5:1–25, 1997

Gabbard GO: Long-Term Psychodynamic Psychotherapy: A Basic Text, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2010

Gabbard GO, Roberts LR, Crisp-Han H, et al: Professionalism in Psychiatry. Washington, DC, American Psychiatric Publishing, 2012

Gullestad SE: The Adult Attachment Interview and psychoanalytic outcome studies. Int J Psychoanal 84:651–668, 2003

Halperin S: The relevance of immigration in the psychodynamic formulation of psychotherapy with immigrants. Int J Appl Psychoanal Studies 1:99–120, 2004

Holmes TH, Rahe RH: Social Readjustment Rating Scale. J Psychosom Res 11:213–281, 1967

Horowitz MJ: Formulation as a Basis for Planning Psychotherapy Treatment. Washington, DC, American Psychiatric Press, 1997

Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984

Kwawer JS, Lerner HD, Lerner PM, et al (eds): Borderline Phenomena and the Rorschach Test. New York, International Universities Press, 1980

Langs RJ: The Bipersonal Field. New York, Jason Aronson, 1976

Leary K: Racial enactments in dynamic treatment. Psychoanalytic Dialogues 10:639–653, 2000

MacKinnon RA, Michels R, Buckley PJ: The Psychiatric Interview in Clinical Practice, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2006

Menninger KA: Theory of Psychoanalytic Technique. New York, Basic Books, 1958

Menninger KA, Mayman M, Pruyser PW: A Manual for Psychiatric Case Study, 2nd Edition. New York, Grune & Stratton, 1962

Millon T: Millon Clinical Multiaxial Inventory Manual. Minneapolis, MN: National Computer Systems, 1977

Peebles MJ: Beginnings: The Art and Science of Planning Psychotherapy, 2nd Edition. New York, Routledge, 2012

Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 144:543–550, 1987

Pine F: Drive, Ego, Object, and Self: A Synthesis for Clinical Work. New York, Basic Books, 1990

Poland WS: The analyst's witnessing and otherness. J Am Psychoanal Assoc 48:16–35, 2000

Rapaport D, Gill MM, Schafer R: Diagnostic Psychological Testing, Revised Edition. Edited by Holt RR. New York, International Universities Press, 1968

Reiser MF: Are psychiatric educators "losing the mind?" Am J Psychiatry 145:148–153, 1988

Schafer R: Psychoanalytic Interpretation in Rorschach Testing: Theory and Application. New York, Grune and Stratton, 1954

Shevrin H, Shectman F: The diagnostic process in psychiatric evaluations. Bull Menninger Clin 37:451–494, 1973

Sperry L, Gudeman JE, Blackwell B, et al: Psychiatric Case Formulations. Washington, DC, American Psychiatric Press, 1992

Stein H, Jacobs NJ, Ferguson KS, et al: What do adult attachment scales measure? Bull Menninger Clin 62:33–82, 1998

Thomä H, Kächele H: Psychoanalytic Practice, Vol 1: Principles. Translated by Wilson M, Roseveare D. New York, Springer-Verlag, 1987

Waelder R: Basic Theory of Psychoanalysis. New York, International Universities Press, 1960

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CHAPTER 4

TREATMENTS IN DYNAMIC PSYCHIATRY

Individual Psychotherapy

Proficiency at individual psychotherapy is perhaps the hallmark of the dynamic psychiatrist. Evolving as it does from psychoanalysis, dynamic psychiatry understandably emphasizes the nuances of the healing relationship between psychotherapist and patient. Space considerations here limit us to a brief overview of the general principles derived from the vast literature on individual psychotherapy. Specific applications of those principles to disorders are demonstrated and explicated in Section II of this volume. Readers who are interested in a more comprehensive discussion of individual psychotherapy should consult any of several comprehensive texts (Basch 1980; Busch 1995; Cabaniss et al. 2011; Gabbard 2010; Luborsky 1984; McWilliams 2004; Roth 1987; Summers and Barber 2009).

Expressive-Supportive Continuum

Psychotherapy that is based on the technical principles of formal psychoanalysis has been designated by a number of different names: expressive, dynamic, psychoanalytically oriented, insight oriented, exploratory, uncovering, and intensive, to name a few. This form of treatment, geared toward analyzing defenses and exploring the transference, has traditionally

been viewed as wholly different from another entity known as supportive psychotherapy. The latter, which is more oriented to suppressing unconscious conflict and bolstering defenses, has been widely regarded as inferior to expressive therapy. This tendency is reflected in the clinical maxim that has guided psychotherapists for years: "Be as expressive as you can be, and as supportive as you have to be" (Wallerstein 1986, p. 688).

A number of authors have expressed concern about this traditional dichotomy (Gabbard 2010; Horwitz et al. 1996; Pine 1976, 1986; Wallerstein 1986; Werman 1984; Winston et al. 2004). One problem with the distinction is the implication that supportive psychotherapy is not psychoanalytically oriented. In practice, many forms of supportive psychotherapy are guided by psychoanalytic understanding every step of the way. Moreover, the dichotomy portrays expressive psychotherapy and supportive psychotherapy as highly discrete entities when, in fact, they rarely occur in pure form anywhere (Wallerstein 1986; Werman 1984). Finally, the value distinction associated with the greater prestige of expressive psychotherapy or psychoanalysis has always carried with it the assumption that change achieved as a result of insight or intrapsychic conflict resolution is somehow superior to that achieved through supportive techniques. No hard data support this assumption.

At the conclusion of a longitudinal study of 42 patients treated in The Menninger Foundation Psychotherapy Research Project, Wallerstein (1986) determined that all forms of psychotherapy contain a mixture of expressive and supportive elements and that changes achieved by the supportive elements are in no way inferior to those achieved by the expressive elements. Rather than regarding expressive psychotherapy and supportive psychotherapy as two distinct modalities of treatment then, we should view psychotherapy as taking place on an expressive-supportive continuum, which is in closer keeping with the reality of clinical practice and with empirical research. With certain patients and at certain points in the therapy, the therapy will be weighted more heavily toward expressive elements, whereas with other patients and at other times, the therapy will require more attention to supportive elements. As Wallerstein (1986) noted, "All proper therapy is always both expressive and supportive (in different ways), and the question at issue at all points in every therapy should be that of expressing *how* and *when,* and supporting *how* and *when*" (p. 689).

Individual psychotherapy geared to this continuum might best be termed *expressive-supportive* or *supportive-expressive*. Even psychoanalysis, situated at the most extreme point on the expressive end of the continuum, contains supportive elements. Meanwhile, most supportive psychotherapies at the opposite end of the continuum provide insight and understanding from time to time. Hence, the effective dynamic therapist will shift flexibly

back and forth along the expressive-supportive continuum depending on the needs of the patient at a given moment in the psychotherapy process.

The concept of the expressive-supportive continuum provides a framework for considering the goals, characteristics, and indications for individual psychotherapy.

Expressive-Supportive Psychotherapy

Goals

Historically, insight and understanding were always considered the ultimate goals of psychoanalysis and of psychotherapy derived from psychoanalytic principles. Since the 1950s, however, there has been considerable acceptance of the notion that the therapeutic relationship itself is healing independently of its role in delivering insight. Loewald (1957/1980) noted that the process of change is "set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new 'object relationship' between the patient and the analyst" (p. 224).

Although most psychoanalytic therapists endorse goals involving insight and the therapeutic relationship, there is variation in which dimension is given the most emphasis. Some focus more on conflict resolution through interpretation, whereas others stress the importance of developing authenticity or "the true self" (Winnicott 1962/1976). Some therapists are more ambitious regarding therapeutic outcomes; others conceptualize the psychotherapeutic process as a search for truth about oneself (Grinberg 1980). Still others believe that the capacity for reflectiveness about one's internal world should be the goal (Aron 1998). Kleinians would view the goal as the reintegration of aspects of the self that were previously lost through projective identification (Steiner 1989). Those influenced by attachment theory (Fonagy 2001) would argue that improved capacity for mentalization is the goal.

From an object relations standpoint, an improvement in the quality of one's relationships is a goal of psychotherapy, regardless of whether it is weighted toward the supportive or the expressive end of the continuum. As internal object relations change in the course of psychotherapy, one is able to perceive and relate to external persons differently. In contemporary practice, patients are much more likely to seek therapy because of dissatisfaction with the quality of their relationships than because of discrete symptoms, as they did in Freud's day. Hence, the importance of this goal cannot be overstated.

In self psychologically oriented psychotherapy, the goals involve strengthening the cohesiveness of the self and helping the patient choose more mature selfobjects, as alluded to in Chapter 2. In Kohut's (1984) words,

"The essence of the psychoanalytic cure resides in a patient's newly acquired ability to identify and seek out appropriate selfobjects as they present themselves in his realistic surroundings and to be sustained by them" (p. 77).

The goal of psychotherapy at the supportive end of the continuum is primarily to help the patient adapt to stresses and strengthen defenses to facilitate the patient's adaptive capacity to handle the stresses of daily living. Furthermore, because supportive techniques are often used in treating patients with serious ego weaknesses, ego building is a crucial aspect of supportive psychotherapies. For example, the therapist may serve as an auxiliary ego, helping patients to test reality more accurately or to anticipate consequences of their actions and thereby improve their judgment. Winston et al. (2004) provide a systematic approach to supportive psychotherapy that is tailored to the individual patient's needs.

Duration

The length of expressive-supportive psychotherapy is essentially independent of the expressive-supportive continuum. Therapies that are highly supportive or highly expressive can be either brief or long. Although definitions of brief and long-term dynamic psychotherapy vary, for purposes of this book, I conceptualize *long-term psychotherapy* as those treatments lasting longer than 6 months or 24 weeks in duration (Gabbard 2010). Most long-term therapies are open-ended, but some are fixed at a set number of sessions from the beginning. In this section I discuss long-term dynamic therapy and address brief therapy near the end of the chapter.

Frequency of Sessions

In contrast to the duration of therapy, the frequency of sessions per week tends to be highly correlated with the expressive-supportive continuum. As a general rule, a greater number of weekly sessions characterizes the expressive end of the continuum. Psychoanalysis, an extremely expressive treatment, is characterized by three to five sessions a week and is usually conducted with the patient lying on a couch while the analyst sits behind the couch. Highly expressive forms of psychotherapy usually involve one to three sessions a week with the patient sitting in an upright position. In contrast, psychotherapy with primarily supportive goals rarely takes place more than once a week and is often provided at a frequency of once a month.

The issue of frequency is connected with the role of transference in the psychotherapeutic process (discussed later in this chapter). Clinical experience has shown that transference intensifies as the frequency of sessions increases. Because the more expressive treatments focus on the transference,

these therapists usually prefer to see their patients at least once a week. In contrast, supportive processes work with transference to a lesser extent and thus do not require one session a week. Also, whereas highly expressive treatments are almost invariably administered in 45- or 50-minute sessions, supportive processes tend to use time more flexibly. Certain patients who require more frequent supportive contacts with the therapist do better with two 25-minute sessions than with one 50-minute session.

The reality of psychiatric practice is that practical matters may outweigh theoretical considerations in determining the frequency of sessions. Some patients may be able to afford only one session a week even though they might do better with three. Other patients, because of inconvenient work schedules or transportation problems, may be able to get to their therapist's office only once a week. Before accepting such limitations, however, the therapist should keep in mind that resistance often finds convenient hiding places. An investigation of these practical limitations may reveal that the patient has greater flexibility of time and money than can be readily acknowledged.

Free Association

Free association is often regarded as the major mode by which the patient communicates to the analyst. This requires patients to relax their usual control over their thought processes in an effort to say whatever comes to mind without censoring their words or thoughts. In actual practice, resistances inevitably intervene when patients try to free-associate. It is often asserted, only half-jokingly, that when a patient is able to free-associate without interference from resistance, then that patient may be ready for termination. Patients may also use free association itself as a resistance to focusing on a particular issue in their current life situation (Greenson 1967).

Free association is also useful in highly expressive therapies, although more selectively than in analysis. The therapist, for example, may ask the patient to associate to various elements of a dream to help both patient and therapist understand unconscious connections that make interpretation of the dream possible. The therapist may also find it useful to use the notion of free association as a way of helping the patient who is stuck or who falls silent. When the patient asks, "What do I do now?" the therapist can respond, "Simply say what comes to mind."

Free association is far less useful further along the continuum toward the more supportively based treatments. As Greenson (1967) pointed out, the process itself requires a mature and healthy ego to maintain a split between an observing ego and an experiencing ego. Patients who are prone to psychosis may become increasingly regressed if allowed to free-associate in a supportive process. Moreover, such patients often lack the ego capacity to re-

flect on their associations and to integrate them into a meaningful and coherent understanding of unconscious issues.

Neutrality, Anonymity, and Abstinence

Between 1912 and 1915, Freud published a series of prescriptions for technique that have formed the basis of what is often referred to as the "classical" model of treatment. Principles such as neutrality, anonymity, and abstinence evolved from those papers. In recent years, however, these concepts have become highly controversial, because it has become increasingly clear that the way Freud actually practiced differed considerably from some of his recommendations in his papers on technique (Lipton 1977; Lohser and Newton 1996). Whereas Freud at times admonished analysts to proceed with emotional detachment, to show nothing of themselves, and to put aside all of their own feelings, written accounts from his own patients demonstrate that he was transparent regarding his mood; frequently gossiped; offered his own opinions about other people, works of art, and current political issues; and was enthusiastically engaged as a "real person." His own subjectivity was very much in evidence. His written prescriptions for technique evidently were based on his concerns about the potential for countertransference acting out in his colleagues rather than what he felt was best to advance the analytic process. Freud was not very "Freudian."

Neutrality is perhaps the most misunderstood aspect of psychoanalytic and psychotherapeutic technique. Freud did not even use the word in his writings. James Strachey translated the German word *Indifferenz* as "neutrality," even though the German word actually implies an undercurrent of emotional participation in the analyst rather than detachment. It is frequently misinterpreted to mean coldness or aloofness (Chessick 1981). Even in the most expressive treatments, emotional warmth is a necessary part of the therapeutic relationship. Similarly, concern for the patient's unique situation is essential to establish rapport.

Therapists who remove themselves from the interpersonal field of the therapy by assuming an aloof, nonparticipatory attitude diminish their effectiveness by closing themselves off to the experience of the patient's internal object world (Hoffman and Gill 1988). There is a broad consensus that the therapist is a participant in the therapeutic process in a spontaneous way (Gabbard 1995; Hoffman and Gill 1988; Mitchell 1997; Racker 1968; Renik 1993; Sandler 1976). As Freud's own practice demonstrated, there is an irreducible subjectivity (Renik 1993) that cannot be eliminated with a mask of anonymity. Moreover, therapists who can allow themselves to respond to the patient's unconscious attempts to transform them into transference objects will gain a much greater appreciation of the patient's internal world. Thera-

pists may become aware of countertransference feelings only *after* they have responded like one of the patient's projected internal objects or self representations (Sandler 1976; see also Gabbard 1995). As noted in Chapter 1, the countertransference that is jointly created by the therapist's subjectivity and the patient's projected internal representations is a source of valuable information in the treatment process.

The most widely accepted contemporary meaning of *neutrality* is the assumption of a nonjudgmental stance regarding the patient's behaviors, thoughts, wishes, and feelings. Anna Freud (1936/1966), who did not use the term, suggested that the analyst should remain equidistant from the id, the ego, the superego, and the demands of external reality. This stance, however, is more of an *ideal* than a realistic position. Therapists are frequently making private judgments about what patients say or do, and a spontaneous, engaged therapist will sometimes reveal those judgments nonverbally if not in overt comments to the patient. Greenberg (1986) redefined neutrality as taking a position equidistant between an old object from the patient's past and the new object of the therapist in the present. This conceptual model may more accurately reflect the therapist's internal process. The therapist is drawn into a role evoked by the patient's internal world and then attempts to become disentangled from that role so as to reflect what is taking place between patient and therapist.

Anonymity has similarly been redefined in contemporary practice. Freud (1912/1958) wrote that the analyst should strive for the opacity of a mirror, but analysts and analytic therapists today recognize that anonymity is a mythical construct. Photographs, books, and other articles of personal interest are all over the therapist's office. When the therapist chooses to speak, both what he or she says and how he or she responds to the patient's material are highly revealing of the therapist's subjectivity. Hence, one is self-disclosing all the time in nonverbal as well as verbal modes. Most analysts and analytic therapists, however, still recognize that there is value in restraint. Revealing highly personal details about the therapist's family or the therapist's personal problems is rarely useful and may burden the patient in a manner that creates a role reversal in which the patient thinks he or she must take care of the therapist. Similarly, making harsh judgments about the patient's thoughts, feelings, or actions may be destructive by compounding the patient's self-criticism.

Abstinence is a third term that has been widely misconstrued by some practitioners. Freud suggested that the analyst needed to withhold gratification of transference wishes so that those wishes could be analyzed rather than satisfied. Today there is wide recognition that partial transference gratifications occur throughout the treatment. The therapist's laughter in response to a joke, the empathic listening intrinsic to psychotherapy, and the warmth

and understanding provided by the therapist all provide gratifications for the patient. The concept of therapeutic or analytic boundaries establishes limits on the physical relationship so that psychological and emotional boundaries can be crossed through the process of empathy, projective identification, and introjection (Gabbard and Lester 2003). Good professional boundaries should not be construed as promoting rigidity or coldness (Gutheil and Gabbard 1998). Good therapists feel free to laugh with the patient, and they may tear up when hearing a sad story. They may also greet the patient with enthusiasm at the beginning of the session. However, they do maintain abstinence regarding the gratification of sexual wishes and any other form of potential exploitation of the patient for their own personal needs.

Interventions

The interventions made by the therapist can be placed into eight categories along an expressive-supportive continuum: 1) interpretation, 2) observation, 3) confrontation, 4) clarification, 5) encouragement to elaborate, 6) empathic validation, 7) psychoeducational interventions, and 8) advice and praise (Figure 4–1).

Interpretation

In the most expressive forms of treatment, interpretation is regarded as the therapist's ultimate decisive instrument (Greenson 1967). In its simplest form, interpretation involves making something conscious that was previously unconscious. An interpretation is an explanatory statement that links a feeling, thought, behavior, or symptom to its unconscious meaning or origin. For example, the therapist might say to a patient who is reluctant to accept anything the therapist says, "Maybe you feel you have to disagree with my observations because I remind you so much of your dad." Depending on the point in therapy and the patient's readiness to listen, interpretations may focus on the transference (as in this example), on extratransference issues, on the patient's past or present situation, or on the patient's resistances or fantasies. As a general principle, the therapist does not address unconscious content via interpretation until the material is almost conscious and therefore relatively accessible to the patient's awareness.

Observation

Observation stops short of interpretation in that it does not attempt to explain unconscious meanings or make causative linkages. The therapist merely notes a nonverbal behavior, a pattern in the therapeutic process, a trace of emotion on the patient's face, or the sequence of moving from one

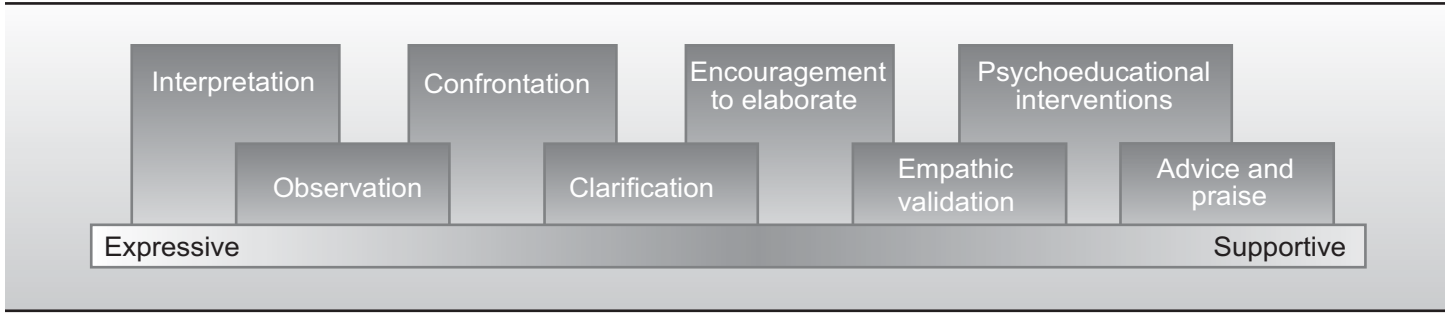

FIGURE 4–1. An expressive-supportive continuum of interventions.

comment to another. A therapist might, for example, say, "One pattern I've noted is that when you enter my office at the beginning of each session, you appear rather frightened and you pull the chair back to the wall before you sit down. Any thoughts about that?" As in this example, the therapist does not speculate about the motive for the behavior but instead invites the patient's collaboration on the matter.

Confrontation

The next most expressive intervention is confrontation, which addresses something the patient does not want to accept or identifies the patient's avoidance or minimization. Unlike observation, which usually targets something outside the patient's awareness, confrontation usually points out the avoidance of conscious material. Confrontation, which is often gentle, carries the unfortunate connotation in common parlance of being aggressive or blunt. The following example illustrates that confrontation is not necessarily forceful or hostile: In the last session of a long-term therapy process, one patient talked at great length about car problems he encountered on the way to the session. The therapist commented, "I think you'd rather talk about your car than face the sadness you're feeling about our last session."

Clarification

Farther along the continuum from expressive to supportive interventions, clarification involves a reformulation or pulling together of the patient's verbalizations to convey a more coherent view of what is being communicated. Clarification differs from confrontation because it lacks the element of denial or minimization. A clarification is aimed at helping the patient articulate something that is difficult to put into words.

Encouragement to Elaborate

Closer to the middle of the continuum come interventions that are neither supportive nor expressive in and of themselves. *Encouragement to elaborate* may be broadly defined as a request for information about a topic brought up by the patient. It may be an open-ended question such as "What comes to mind about that?" or a more specific request as in "Tell me more about your father." Such interventions are commonly used in both the most expressive and the most supportive treatments.

Empathic Validation

Empathic validation is a demonstration of the therapist's empathic attunement with the patient's internal state. A typically validating comment is "I

can understand why you feel depressed about that" or "It hurts when you're treated that way." In the view of the self psychologists, empathic immersion in the patient's internal experience is essential, regardless of the location of the therapy on the expressive-supportive continuum (Kohut 1984; Ornstein 1986). When patients feel that the therapist understands their subjective experiences, they are more likely to accept interpretations. Affirmative interventions (Killingmo 1995) may also be heard as empathic validation. A therapist of a patient who was abused as a child, for example, might say, "You have every right to be angry at your father."

Psychoeducational Interventions

Psychoeducational interventions involve information shared with a patient based on the therapist's training and knowledge. A therapist might, for example, explain the difference between grief and depression.

Advice and Praise

The category of advice and praise includes two interventions that are linked by the fact that they both prescribe and reinforce certain activities. Advice involves direct suggestions to the patient regarding how to behave, whereas praise reinforces certain patient behaviors by expressing overt approval of them. An example of the former is "I think you should stop going out with that man immediately." An example of the latter is "I'm very pleased that you were able to tell him that you would not see him anymore." These comments are on the opposite end of the continuum from traditional psychoanalytic interventions because they are departures from neutrality and to some extent compromise the patient's autonomy in making decisions.

The vast majority of psychotherapeutic processes contain all these interventions at some time during the course of treatment. However, a therapy is classified as primarily expressive or primarily supportive on the basis of which interventions predominate. These associations of interventions with the continuum are not ironclad.

Pine (1986) and Horwitz et al. (1996) advocated supportive techniques to "cushion the blow" of interpretations in the supportive therapy of fragile patients. Werman (1984, p. 83) proposed making "upward interpretations" of transference behavior or feelings to relate them to current situations rather than to early experiences, thereby preventing regression in patients with serious ego weakness. These interventions are the inverse of classical interpretations in that they provide conscious, rather than unconscious, explanations of the patient's behavior or feelings.

Although this continuum of interventions is provided for educational purposes, one must be wary as a psychotherapist not to sound like one is

performing a "procedure" on a patient. Technique should be invisible. From the patient's perspective, psychotherapy should feel like a conversation with a concerned person who is attempting to provide helpful understanding. One must avoid the appearance of making dogmatic pronouncements or speaking in archaic jargon that is off-putting to the patient.

Transference

Freud was fond of saying that what made a therapy process psychoanalytic was a focus on transference and resistance. Certainly all forms of dynamically oriented psychotherapy pay careful attention to the state of the transference. However, the specific manner in which the transference is addressed (or left unaddressed) varies considerably, depending on the expressive-supportive dimension. In formal psychoanalysis, the highlighting and understanding of the transference is of paramount importance, although contemporary analysts would speak of a set or series of transferences rather than *the* transference (Westen and Gabbard 2002). One may encounter mother, father, and sibling transferences all in the treatment of the same patient.

Both psychoanalysis and expressive psychotherapy employ extratransference interpretation as well as transference interpretation. Psychotherapy may be somewhat more limited than psychoanalysis in that it focuses on the transference dispositions most closely related to the presenting problems (Roskin 1982). In actual practice, however, the distinctions between psychoanalysis and expressive psychotherapy are blurred and difficult to delineate.

There is a long-standing tradition to think of transference interpretation as an intervention that is used in highly expressive psychotherapy for patients who are high functioning and neurotically organized. With more disturbed patients, the conventional wisdom has been to use very little transference interpretation because the patients have been regarded as too fragile to reflect on the here and now interaction. However, recent rigorous research has placed this conventional wisdom in question. A randomized control trial of dynamic psychotherapy (Høglend et al. 2006) randomly assigned 100 outpatients to either a group using interpretation of transference or a group that did not use transference interpretation. The group receiving transference interpretation had moderate levels of one to three per session. Although no overall differences in outcome between the two treatment cells were found, an unexpected finding was a reversal of the conventional wisdom. Patients with impaired object relations benefited more from therapies using transference interpretation than those without transference interpretation. This effect was sustained at 3-year follow-up. In a subsequent study (Høglend et al. 2011), the investigators examined the effects of transference work in the context of therapeutic alliance and quality of object relations in

more detail. They found that for patients with a strong alliance and higher levels of object relations, the specific effect of transference work tended to be smaller and only marginally significant. Transference work had the strongest specific effect for patients with low quality of object relations scale scores within the context of a weak alliance.

One implication of the study is that transference work may be crucial when treating patients who have difficulties establishing stable and fulfilling relationships. In other words, the therapeutic alliance will be more challenging for these patients unless one can examine the here and now situation with the patient and understand his or her anxieties about forming an alliance with the therapist. In so doing, the therapist is also helping the patient understand anxieties inherent in establishing stable relationships outside the transference. Another implication of the study is that patients with high levels of object relations may not require a good deal of transference interpretation. Those who are resourceful and who have a positive alliance may feel interpretation of transference is jarring. Paradoxically, that approach may result in increased resistance. This finding may be a reflection of the long-standing admonition of therapists that transference should not be interpreted until it becomes a resistance.

As noted in Chapter 1, transference is often viewed today as having a bidimensional quality involving a repetition of past experience with old objects on the one hand and a quest for a new object or selfobject experience that will be reparative and corrective for the patient on the other. In addition, the notion of transference as distortion has become more complex. The therapist must avoid a "blaming" approach to transference interpretation, because the patient may be legitimately responding to real behaviors or attitudes of the therapist. The therapist must always engage in ongoing self-scrutiny to sort out the repetitive, "template" aspect of transference stemming from the patient's intrapsychic world and the real contributions of the therapist to the interaction (Gabbard 1996; Hoffman 1998; Mitchell 1997).

In therapies designed primarily to be supportive, the therapist is involved in the same process of monitoring transference developments and countertransference responses. The transference is noted inwardly but is usually not addressed or interpreted to the patient. The treatment goal in refraining from interpretation is to build a solid therapeutic alliance along with a positive transference (Wallerstein 1986). This combination of positive transference attachment and collaborative therapeutic alliance is the mechanism of the "transference cure," whereby the patient works hard to please the therapist and to make the therapist proud. Although changes derived from this model have traditionally been disparaged as inferior to those stemming from conflict resolution, research suggests that they may be stable and lasting (Horwitz 1974; Wallerstein 1986).

Resistance

As noted in Chapter 1, resistance involves the emergence of the patient's characterological defenses within the therapeutic situation. In the more expressive therapies, analyzing and understanding resistance is part of the daily bread-and-butter work of the therapist. If, for example, the patient is consistently late to sessions or consistently silent during them, the therapist may regard these resistances with interest and curiosity rather than devalue them as defiant and willful behavior. Resistances are not met with proscriptions or censure. Instead, the therapist enlists the patient's help in understanding the origins of the resistance and then addresses the resistance with interpretation.

Resistance related to transference issues is referred to as *transference resistance*. This involves interferences with the therapeutic work deriving from transference perceptions. For example, a patient may feel unable to talk about masturbatory fantasies because he is convinced that his therapist disapproves of masturbation. To prevent receiving a negative judgment from the therapist, the patient therefore chooses to remain silent. In the parlance of object relations theory, a transference resistance may be understood as the patient's unconscious tendency to cling tenaciously to a particular internal object relationship. This may manifest itself as a therapeutic stalemate in which the therapist is repeatedly related to as someone else.

Students of psychoanalysis and psychoanalytic psychotherapy often raise the question, "Resistance to what?" Friedman (1991) noted that the true significance of resistance is that the feelings associated with it may compel the patient into nonreflective action instead of reflective observation. He pointed out that what is resisted is a particular mental attitude that he describes as "a simultaneous conscious activation of repressed wishes and a cool contemplation of their significance, so that they are experienced both as wishes and as objective features of the conflicted self" (p. 590). Moreover, the current emphasis on intersubjectivity would also suggest that the resistance of the patient may be paralleled by a counterresistance in the therapist that may collude with the patient's difficulties in achieving the reflective space necessary for psychoanalytic treatment.

In Chapter 2, I noted the different perspective on resistance that is held by self psychologists. They regard resistances as healthy psychic activities that safeguard the growth of the self (Kohut 1984). Rather than interpret resistances, they empathize with the patient's need for them. This view is in keeping with their concern that the classical approach of pursuing the content beneath resistance has moralistic overtones. However, this empathic approach has led some analysts to regard the self psychological technique as fundamentally supportive.

As implied by the previous comments about self psychology, resistance is viewed as essential and adaptive in the context of predominantly supportive psychotherapy. Resistances are often manifestations of defensive structures that need to be bolstered as part of therapy. The therapist might even encourage resistance by pointing out to the patient that certain matters are too upsetting to discuss and should be postponed until a more auspicious moment. Similarly, delay mechanisms may be reinforced in the interest of supporting a weakened ego beset by impulses. When a patient's actions usurp verbalization of painful feelings, as in acting-out, the therapist may be forced to set limits on self-destructive behavior rather than to interpret the resistance to talking, as in expressive treatment. This limit setting may involve hospitalization or insistence that the patient turn over illegal drugs to the therapist.

Working Through

Interpretations rarely result in "Aha!" responses and dramatic cures. Typically, they are warded off by the forces of resistance and require frequent repetition by the therapist in different contexts. This repetitive interpretation of transference and resistance until the insight has become fully integrated into the patient's conscious awareness is known as *working through*. Although the therapist's efforts are necessary, the patient does part of the work of accepting and integrating the therapist's insights between the actual therapy sessions (Karasu 1977). The triangle of insight (Menninger 1958) is a useful conceptual model for the process of working through (see Figure 4–2). Over the course of therapy, the therapist notes certain patterns 1) in the patient's outside relationships and then links them to 2) transference patterns and to 3) antecedent relationships with family members. Eventually, the patient makes these unconscious linkages conscious. These patterns can be tracked throughout the course of therapy as they relate to the three sides of the triangle, and they can be pointed out to the patient each time they appear. As the patient sees a pattern come up again and again in new contexts, it becomes less alien, and the patient gains greater mastery over it.

This same model can be restated in terms of object relations theory. Recurrent self–object–affect constellations appear in the transference, in current extratransference relationships, and in memories of past relationships. In self psychological terms, the pattern may be the expectation of mirroring or the need to idealize others. Regardless of which theoretical model is employed, however, all schools of thought view the re-experiencing of these central relationship patterns in the transference as critically important to a positive outcome. This working-through process is applied almost exclusively to treatments with a significant expressive component—it is rarely used to characterize primarily supportive processes.

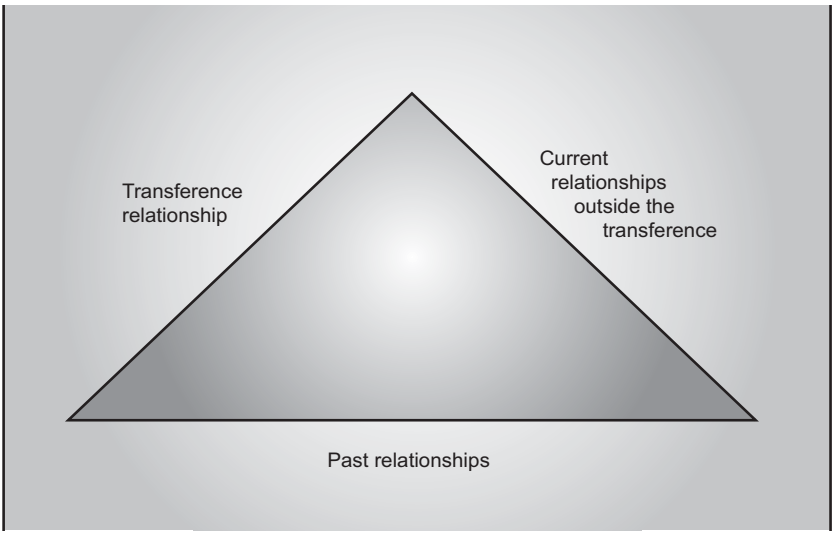

FIGURE 4–2. Triangle of insight (modeled after Menninger 1958).

Use of Dreams

In psychoanalysis and highly expressive forms of therapy, the interpretation of dreams is valued as "the royal road" to an understanding of the unconscious (Freud 1900/1953, p. 608). The patient's associations to the dream elements are used to understand the latent or hidden content of the dream that lies behind the manifest or overt content. The symbols of the dream can then be interpreted to help the patient further understand the unconscious issues in the dream. (See Gabbard 2010 for a more systematic account of working with dreams.)

In psychotherapies on the supportive end of the continuum, the therapist listens carefully to the patient's dream and thinks about it in the same way as would an expressive therapist. However, the therapist limits interpretive efforts to upward interpretations (Werman 1984, p. 83) that help the patient associate the dream with conscious feelings and attitudes toward the therapist as a real person and to other reality situations in waking life. Free association to the dream is not encouraged because it might lead to further regression.

In between the supportive and expressive ends of the continuum, there is room for selective dream interpretation in which the therapist relates the dream to conscious or unconscious issues in a limited sector of the patient's psychological life. The focus is more on the psychological surface than on the depths of the unconscious and is geared to the specific goals of the psychotherapy (Werman 1978).

Therapeutic Alliance

Freud (1913/1958) was aware that patients are unlikely to be able to use interpretive understanding unless a proper rapport has first been established. This relatively nonconflictual and rational rapport that the patient has with the analyst was termed the *working alliance* by Greenson (1965/1978). It involves the patient's capacity to collaborate productively with the therapist because the therapist is perceived as a helping professional with good intentions. A patient's relationship with his or her parents tends to predict the nature of the working alliance with the therapist (Lawson and Brossart 2003).

Major research efforts on the therapeutic alliance have confirmed its influence on the process and outcome of psychotherapy (Frieswyk et al. 1986; Hartley and Strupp 1983; Horvath and Symonds 1991; Horwitz 1974; Horwitz et al. 1996; Lawson and Brossart 2003; Luborsky et al. 1980; Martin et al. 2000; Marziali et al. 1981). Much of this research points to the strength of the therapeutic alliance as a dominant factor in the outcome of a broad range of therapies (Bordin 1979; Hartley and Strupp 1983; Horvath and Symonds 1991; Lawson and Brossart 2003; Luborsky et al. 1980; Martin et al. 2000).

A recent meta-analysis involving 200 research reports and more than 14,000 treatments (Flückiger et al. 2012) found that there is a robust correlation between the therapeutic alliance and positive outcome. The link is present regardless of whether or not disorder-specific manuals are used and regardless of the type of psychotherapy or the specificity of outcomes.

One application of this extensive research is that in all psychotherapies, regardless of their point on the expressive-supportive continuum, therapists must attend early on to the establishment and maintenance of the therapeutic alliance. This focus does not require the formation of a positive transference that will not allow the expression of negative feelings. Rather, therapists must help their patients identify their treatment goals and then must ally themselves with the healthy aspects of their patients' egos that are striving to reach those goals. Patients are then more likely to experience their therapists as collaborators who are working *with* them rather than *against* them. When working more supportively with patients with fragile egos, therapists find that the alliance is more difficult to develop and maintain (Horwitz et al. 1996). The borderline patient's chaotic transference reactions, for example, interfere with the formation of an alliance, and it is a major therapeutic accomplishment for the patient to eventually be able to perceive the therapist as a helpful person collaborating on common goals (Adler 1979).

Mechanisms of Change

The mechanism of change in the more expressive forms of psychotherapy depends in part on the goals of the treatment. Hence, views of change mecha-

nisms often vary according to these treatment goals. Insight and healing relational experiences, once thought to be mutually exclusive, are now regarded as compatible processes that work synergistically for therapeutic change (Cooper 1992; Gabbard 2010; Jacobs 1990; Pine 1998; Pulver 1992). In other words, a therapeutic relationship probably will not be sustained unless there is insight into what is going on in the relationship. Conversely, the relationship itself may provide an interpretive understanding of the patient's dynamics.

There is also greater acknowledgment of multiple modes of therapeutic action that vary according to the patient. Blatt (1992, 2004) identified two types of patients who change in different ways. *Introjective* patients are ideational and preoccupied with establishing and maintaining a viable self-concept rather than with establishing intimacy in the interpersonal realm. They appear to be more responsive to insight through interpretive interventions. On the other hand, *anaclitic* patients are more concerned with issues of relatedness than self-development and gain greater therapeutic value from the quality of the therapeutic relationship than from interpretation.

Patients change in a variety of ways using different therapeutic mechanisms. Recent developments in cognitive neuroscience help us articulate how change occurs and what therapists may do to facilitate change (Gabbard and Westen 2003). Links between associational networks are modified as a result of therapy so that a representation of an authority figure, for example, may not trigger the same emotional reaction after therapy as it did before. Moreover, new associative linkages are strengthened that were previously weak. In short, lasting change requires a relative deactivation of problematic links in activated networks associated with an increased activation of new, more adaptive connections. These alterations in associational networks may be facilitated by several techniques. The therapist may point out distinctions between different ways that patients reflect on themselves, conscious attitudes toward themselves, and how they tolerate feelings and become aware of them. Therapists may also address the frequency or intensity of conscious emotional states and help patients examine their conscious coping styles (Gabbard 2010; Gabbard and Westen 2003).

In addition, through interpretation, therapists provide insight into a wide array of mental events that are interconnected: fears, fantasies, wishes, expectations, defenses, conflicts, transferences, and relational patterns. Therapists may, for example, point out how a current problem with a supervisor is related to problems with a parent in the past. Such insight may also serve to modify connections among the nodes of a neural network.

In addition to interpretation, therapists provide observation from an outside perspective. They point out how certain habitual patterns of the patient reflect emotional conflict and turmoil within. This function of the psychotherapist is much like viewing oneself on videotape and learning how one

comes across to others. No matter how intelligent or insightful a patient may be, therapists always have an outside perspective—one that is different from the patient's (Gabbard 1997). However, for effective working through of the patient's issues, therapists must also validate the patient's subjective internal experience with empathy and understanding (Gabbard 2010). Hence, the optimal position of the therapist is to oscillate between observing from a third-person perspective and emphatically validating a figure who is attuned to the first-person perspective. Fonagy (1999) stressed that a crucial avenue for therapeutic change may lie in the patient's increasing capacity to "find himself" in the therapist's mind. By commenting on feelings and nonverbal communications that are seen only by the therapist, the patient may begin to assemble a portrait of himself based on the therapist's observations. Implicit patterns thus become more available for conscious reflection.

In a review of the comparative psychotherapy process literature, Blagys and Hilsenroth (2000) identified seven techniques that distinguish psychodynamic forms of therapy from cognitive-behavioral therapy. These features are summarized in Table 4–1.

Diener et al. (2007) conducted a meta-analysis on how the therapist facilitates the patient's emotional experience, a central thrust of dynamic therapy, as reflected in Table 4–1. They found that there is a statistically significant relationship between therapist facilitation of patient emotional experience or expression and positive outcome when more than one type of outcome construct is included. They noted several specific techniques that appear to be helpful in this regard, including making specific references to emotional indicators in the patient, increasing the patient's awareness of feelings that he or she may be avoiding, and focusing specifically on shifts in the patient's mood: muscle tension, tears, or other reflections of emotional states. These investigators noted that observing the affective states must precede any effort to interpret any meaning.

Another major mode of therapeutic action comes from elements of the therapeutic relationship itself that do not involve specific insight and understanding. Patients experience a new kind of relationship that may lead to internalization of the therapist's emotional attitudes and identification with the therapist's way of approaching problems. In addition, the therapist may be internalized as an internal presence that is soothing and comforting to the patient. The therapist's function as someone who contains and processes meaningful interactions is also internalized as a result of therapy.

In addition to techniques that are aimed at fostering insight and those that derive from the therapeutic relationship, there are secondary strategies that may be useful in bringing about change. These include the implicit or explicit use of suggestion, the confrontation of dysfunctional beliefs, the examination of a patient's problem-solving methods, forms of self-disclosure that help the

TABLE 4–1. Distinctive features of technique in psychodynamic psychotherapy

Focus on affect and expression of emotion
Exploration of attempts to avoid aspects of experience
Identification of recurring themes and patterns
Discussion of past experience
Focus on interpersonal relations
Focus on therapeutic relationship
Exploration of wishes, dreams, and fantasies

Source. Blagys and Hilsenroth (2000)

patient understand the impact that he or she has on others, and affirmation or validation of the patient's experience (Gabbard and Westen 2003).

In Wallerstein's (1986) analysis of data from The Menninger Foundation Psychotherapy Research Project, he found that changes produced by predominantly supportive measures involved a variety of mechanisms. The transference cure connected with the unanalyzed positive dependent transference has already been mentioned. One variant is the "therapeutic lifer" who loses the gains if termination is attempted but who can be sustained at a high level of functioning as long as contact with the therapist continues indefinitely. Many patients are able to reduce the contacts to once a month or less but are prone to decompensate if there is any talk of termination. Another supportive mechanism of cure is "transfer of the transference," in which the positive dependency in the therapeutic relationship is transferred to another person, usually a spouse. Yet another mechanism is termed "the antitransference cure" and involves change through defiance and acting-out against the therapist. Still other patients in Wallerstein's sample changed via a narrowly defined variant of the corrective emotional experience in which the patient's transference behavior was met by the therapist with steady, nonjudgmental concern. Finally, some patients appear to benefit from a supportive treatment geared to giving direct, nonjudgmental advice. Wallerstein termed this process "reality testing and re-education."

The interactions between therapist and patient in all therapies are accompanied by nonconscious affective and interactive connections that have been referred to by Lyons-Ruth et al. (1998) as *implicit relational knowing*. This knowing may occur in moments of meeting between therapist and patient that are not symbolically represented or dynamically unconscious in the ordinary sense. In other words, some changes in treatment occur in the realm of procedural knowledge involving how to act, feel, and think in a particular relational context.

Specific moments of mutual recognition—a look, a shared bit of humor, a feeling of intense involvement—may be remembered long after specific in-

terpretations are forgotten. Psychotherapy can be viewed as a new attachment relationship that restructures attachment-related implicit memory. Stored prototypes are modified by new interactions with an affectively engaged therapist (Amini et al. 1996). At the same time, explicit memory involving a conscious narrative is altered by interpretive understanding.

Another implication of this model of therapeutic action is that the expressive-supportive continuum of interventions depicted in Figure 4–1 does not account for all therapeutic change. Many moments of meeting between therapist and patient occur outside the realm of "technique" (Stern et al. 1998). Spontaneous human responses by the therapist may have a powerful therapeutic impact.

Recent research indicates that another reflection of change involves a modest improvement in defenses over long-term psychodynamic psychotherapy (Perry and Bond 2012). In a naturalistic study of 21 patients with severe depression and/or personality disorders who had been treated for a median of 228 weeks, the investigators found that improvement in defenses during the first 2.5 years was associated with significant improvement in external measures of symptoms and life functioning 5 years later. In other words, the patients relied less on primitive defenses and more on the defenses that are considered more mature, demonstrating that even relatively modest improvement in defenses can be associated with substantial improvement in real life.

Termination

Psychotherapists must resign themselves to living a professional life of continued loss. Patients come into their lives, share their most intimate thoughts and feelings, and then may never be heard from again. Because loss is an unpleasant experience for all of us, the ending of a psychotherapy process brings with it the vulnerability to transference and countertransference acting-out. Although an orderly, mutually agreed upon termination is the ideal, half or more of outpatients discontinue treatment prematurely (Baekeland and Lundwall 1975), and less than 20% of patients in community mental health center populations undergo a mutually negotiated termination process (Beck et al. 1987).

Termination may occur for a variety of reasons. It may be forced by external circumstances in the life of the therapist or the patient. Insurance companies or managed care firms may dictate the ending. The patient's own financial resources may be exhausted. The patient may abruptly leave and refuse to return because of dissatisfaction with the therapist or anxiety over highly charged subject matter. The therapist may feel that maximum benefit has been reached and recommend termination, or the therapist and the patient may mutually agree upon a termination date.

Indications for termination are not absolute, but a good rule of thumb is that the patient is ready to stop when the goals of psychotherapy are reached and/or the patient is able to internalize the psychotherapeutic process without the presence of the therapist. Presenting symptoms may have been eliminated or improved, the superego may have been modified, the patient's interpersonal relationships may have changed, and the patient may feel a new sense of independence. In cases of predominantly supportive psychotherapy, indications include a stability in the patient's functioning, a reversal of any regressive processes, and an overall quiescence of symptoms. Clinicians must always recognize, however, that a certain subset of highly disturbed patients may require ongoing, infrequent therapy indefinitely (Gabbard and Wilkinson 1994; Wallerstein 1986).

Once the therapist and patient have mutually agreed upon a date for termination, a number of transference manifestations may emerge. Some of the original symptoms may reappear (Dewald 1971; Roth 1987). Negative transference may surface for the first time when the patient realizes that the therapist will not be there forever. Therapists may need to assist their patients in mourning the fantasy of ultimate gratification in the transference. In supportive treatments, the therapist must stress continuing positive rapport and avoid the mobilization of unmanageable negative transferences (Dewald 1971). Because of the formidable challenges faced by the therapist during the termination process, many therapists prefer to continue the same frequency of sessions right up to the end. Others "wean" the patient by gradually decreasing the frequency of sessions.

When a patient terminates therapy unilaterally, therapists must deal with the feeling that they have somehow failed the patient. In such situations, therapists might remind themselves that the patient always has the privilege of ending the treatment and that such terminations may ultimately result in good outcomes. On the other hand, therapists can only help those patients who wish to be helped and who wish to collaborate in a process. Each therapist will have failures, and the limits of the craft must be recognized and accepted.

In instances in which the termination is the therapist's unilateral decision, a different set of problems arises. When the termination is forced because of training requirements to rotate to a new clinical assignment, the therapist-in-training may wish to avoid discussing the termination process because of guilt feelings. Some therapists will even avoid letting their patients know of their departure until the last minute. In general, whenever external constraints are placed on the duration of the process, patients should be informed as early as possible so that their reactions can be accommodated as part of the treatment. When a therapist must leave the treatment for external reasons, patients often feel that the arbitrary nature of certain parental

relationships has been re-created (Dewald 1971). Whatever the impact may be on the patient, the essential point is that the patient's reactions must be thoroughly explored even though the therapist may find it disconcerting to hear about the patient's anger and resentment. (For a fuller discussion of the complexities surrounding termination, see Gabbard 2010.)

Indications for Expressive or Supportive Emphasis in Psychotherapy

Before considering the indications for weighting a psychotherapy process toward the expressive or supportive end of the continuum, therapists must understand that predicting who will respond to what form of psychotherapy is an uncertain business at best. There is some indication in the literature that healthier patients tend to do better in psychotherapy than more severely ill patients (i.e., the rich get richer [Luborsky et al. 1980]). A study of who will benefit from psychotherapy (Luborsky et al. 1988) concluded that both a positive relationship at the outset and a congruence between the core conflictual relationship theme and the content of interpretations were predictors of good outcome. The strength of the therapeutic alliance in the first session or two may be the best predictor of eventual outcome, according to empirical research on the subject (Horvath and Symonds 1991; Martin et al. 2000; Morgan et al. 1982). However, this variable is greatly affected by the nature of the patient–therapist match, which is almost impossible to quantify.

Several patient characteristics can help clinicians decide whether a predominantly expressive or predominantly supportive focus is indicated (Table 4–2). Indications for a highly expressive modality, such as psychoanalysis, include 1) a strong motivation to understand oneself, 2) suffering that interferes with life to such an extent that it becomes an incentive for the patient to endure the rigors of treatment, 3) the ability not only to regress and give up control of feelings and thoughts but also to quickly regain control and reflect on that regression (regression in the service of the ego) (Greenson 1967), 4) tolerance for frustration, 5) a capacity for insight or psychological mindedness, 6) intact reality testing, 7) meaningful and enduring object relations, 8) reasonably good impulse control, and 9) ability to sustain a job (Bachrach and Leaff 1978). The ability to think in terms of metaphor and analogy, where one set of circumstances can be grasped as parallel to another, also augurs well for expressive treatment. Finally, reflective responses to trial interpretations during the evaluation period may suggest a suitability for expressive therapy.

Two general indications for supportive psychotherapy are chronic ego weaknesses or defects and regression in a healthy person who is undergoing a severe life crisis. The former might include problems such as impaired reality testing, poor impulse control, and poor anxiety tolerance. Brain-based

TABLE 4–2. Indications for expressive or supportive emphasis in psychotherapy

Expressive	Supportive
Strong motivation to understand	Significant ego defects of a chronic nature
Significant suffering	Severe life crisis
Ability to regress in the service of the ego	Low anxiety tolerance
Tolerance for frustration	Poor frustration tolerance
Capacity for insight (psychological mindedness)	Lack of psychological mindedness
Intact reality testing	Poor reality testing
Meaningful object relations	Severely impaired object relations
Good impulse control	Poor impulse control
Ability to sustain a job	Low intelligence
Capacity to think in terms of analogy and metaphor	Little capacity for self-observation
Reflective responses to trial interpretations	Organically based cognitive dysfunction
	Tenuous ability to form a therapeutic alliance

cognitive dysfunction and lack of psychological mindedness are other indications for weighting the psychotherapy in a supportive direction. Patients with severe personality disorders who are prone to a great deal of acting out may also require supportive measures (Adler 1979; Luborsky 1984). Other patients who frequently do better with a predominantly supportive approach are those with seriously impaired object relations and a tenuous ability to form a therapeutic alliance. Individuals who are in the midst of a serious life crisis, such as divorce or death of a spouse or child, or who are affected by a catastrophe such as a flood or tornado, are rarely suitable for expressive or exploratory approaches because their ego may be overwhelmed by the recent trauma. After beginning a supportive process, however, these patients will sometimes shift in an expressive direction.

Although these indications are focused on the two ends of the expressive-supportive continuum, most patients will present with a mixture of indications, some pointing in the expressive direction and others pointing toward the supportive end. The therapist must continually assess how—and when—to be supportive or expressive as the process proceeds. Moreover, in a naturalistic prospective longitudinal study (Scheidt et al. 2003), investigators

found that in the private practice of psychodynamic psychotherapy, psychiatric diagnosis and symptom severity contribute little to the decision to accept a patient for treatment. The therapist's emotional response to the patient and the patient's motivation were the strongest determinants of which patients received dynamic therapy.

Brief Psychotherapy

In the past 20 years, there has been a burgeoning interest and literature on forms of brief psychotherapy derived from psychoanalytic principles. Methodologically sophisticated comparisons with other treatment modalities have demonstrated that brief dynamic psychotherapy is just as helpful as other psychotherapies (Crits-Christoph 1992). A number of superb texts outline detailed guidelines for clinicians (Book 1998; Budman 1981; Davanloo 1980; Dewan et al. 2004; Garfield 1998; Gustafson 1986; Horowitz et al. 1984a; Malan 1976, 1980; Mann 1973; Sifneos 1972). Also available are several comprehensive review articles that compare and contrast the approaches and attempt to integrate them (Gustafson 1984; MacKenzie 1988; Ursano and Hales 1986; Winston and Muran 1996). Despite the variations and approaches, there are striking areas of consensus regarding the practice of brief psychotherapy. This brief discussion emphasizes those points of agreement.

Indications and Contraindications

In many ways, the indications for brief dynamic psychotherapy of an expressive nature parallel those associated with long-term expressive psychotherapy. Important selection criteria include 1) the capacity for insight or psychological mindedness, 2) high levels of ego functioning, 3) strong motivation to understand oneself beyond mere symptom relief, 4) the capacity to form in-depth relationships (particularly an initial alliance with the therapist), and 5) the ability to tolerate anxiety. An additional point is central to selecting patients for brief psychotherapy—namely, the issue of focus. By virtue of its brevity, time-limited psychotherapy must be focal in nature, in contrast to the pervasive breadth of psychoanalysis and highly expressive open-ended psychotherapy. Therefore, to proceed with brief therapy, the therapist and patient must identify the dynamic focus for the problem within the first or second evaluation session. Finally, brief therapy may be particularly helpful for relatively healthy individuals going through a developmental transition, such as moving from home, changing jobs, or having a first child.

Contraindications include the same factors that contraindicate long-term psychotherapy of an expressive nature, but they also encompass other

features that might not contraindicate longer-term treatment. If a patient cannot circumscribe the problem to a focal dynamic issue, brief psychotherapy is contraindicated. Personality disorders that are amenable to longer-term expressive approaches cannot be expected to respond to short-term therapy unless the patient presents with a situational complaint, such as grief, and unless the goals are limited to this temporary complaint (Horowitz et al. 1984a). Although some authors exclude chronically phobic or obsessional patients, Davanloo (1980) viewed patients with such symptoms as highly amenable to his style of brief psychotherapy.

Empirical research has confirmed that good outcomes in brief dynamic psychotherapy depend on careful selection of patients. Quality of object relations is one of the best predictors of outcome (Høglend 2003; Piper et al. 1990). Simply put, those with a capacity for more mature object relatedness tend to do better in treatment. Another study (Vaslamatzis et al. 1989) demonstrated higher dropout rates in patients who were not truly suitable for brief psychotherapy. A third project determined that bereaved patients who were highly motivated and better organized were more suitable for expressive brief therapy, whereas those with less motivation and lower organizations of the self-concept did better with supportive approaches (Horowitz et al. 1984b). Patients with a history of problematic interpersonal relationships or a diagnosis of personality disorder generally are not suited for brief therapy. Research suggests they require more than 35 sessions to achieve stable dynamic changes (Høglend 2003).

Number of Sessions

Different authors recommend different ways of handling the actual time limit of brief therapy. Mann (1973), who saw an acceptance of limits and a renunciation of magical expectations as central to the therapy process, insisted on a limit of 12 sessions. Davanloo (1980), on the other hand, averaged 15–25 sessions and did not set a specific termination at the beginning of treatment. Although Sifneos (1972) also refused to stipulate a specific number of sessions, his treatments tended to last only 12–16 sessions. As a general rule, then, brief therapy lasts as little as 2–3 months or as long as 5–6 months and involves a range of 10–24 sessions.

Process of Therapy

Although the techniques associated with long-term therapy are by and large applicable to brief treatments, their most striking difference is that they are markedly accelerated. Therapists must formulate their central hypothesis more quickly and must proceed to interpret resistances to insight earlier and

more aggressively. Authors differ in terms of their degree of confrontation in dealing with resistances, but all acknowledge that the intensity of the process stirs up anxiety. Gustafson (1984) stressed that confronting resistances requires an *empathic* frame of reference or the patient will feel attacked. Malan (1976), appropriating Karl Menninger's triangle of insight, suggested that the therapist's primary task is to link the focused complaint to patterns in past relationships, in present relationships, and in the transference. A brief example illustrates this process.

> Mr. B, a 35-year-old military man, came to therapy with a chief complaint of "I'm too domineering." He had been married for 8 months to his second wife, whom he said was already complaining about this character trait, just as his first wife had. In the second session Mr. B came in and began talking about the softball game he had just left. He disagreed with the umpire's decision to call him out at home plate but noted, "You don't argue with the umpire. What he says goes. You're asking for trouble if you do." Later in the session he spoke of his father, who was a lieutenant colonel in the army. He described his father as an arbitrary man with whom you could not negotiate. The patient had always believed that his own opinions were not valued by his father. Still later in the session, Mr. B said, "I don't think 12 sessions are enough. But I guess we have to limit it to that. You said so."
>
> At this point the therapist made an intervention that joined together the three sides of the triangle: "It sounds like your experiences with the umpire, your father, and me are all similar—you feel we make arbitrary decisions in which you have no say." The therapist was then able to formulate an interpretation regarding the way the patient treated both his first and second wife. He was turning the passively experienced trauma of being completely dominated by his father into an experience of active mastery with his wife. He dominated her the way his father had dominated him.

Book (1998) adapted Luborsky's (1984) core conflictual relationship theme to the process of brief dynamic psychotherapy. He stressed that therapists should identify three components in the patient as quickly as possible during the assessment phase: a wish, a response from the other, and a response from the self. The patient will tell stories describing relationship episodes in which these three components will soon become evident. The goal of psychodynamic brief therapy within this formulation is to help the patient actualize his or her wish by mastering the fear of how others will respond. This mastery is aided by conceptualizing that feared response as a form of a transference distortion.

One adaptation that is generally necessary in the shift from long-term dynamic therapy to brief dynamic therapy is a more judicious use of transference interpretation. Eleven different studies have found a negative association between frequent transference interpretations and immediate or long-term outcome (Høglend 2003). This guideline is only a general principle. More fre-

quent use of transference interpretations may be more productive with some subgroups of patients, depending on the clinical characteristics and the capacity to work in the transference.

Brief Supportive Psychotherapy

There is much less literature on brief psychotherapies of a supportive nature. The primary indication for brief supportive psychotherapy is a relatively healthy person who is undergoing a specific life crisis. The techniques involved are similar to those of long-term supportive psychotherapy, namely, ego building, facilitating the development of a positive transference without interpreting it, and restoring previously adaptive defenses, as illustrated in the following example:

> Ms. C, a 52-year-old woman, came for consultation regarding feelings of guilt and anxiety related to her 23-year-old daughter's out-of-wedlock pregnancy. The psychiatrist listened and empathized with the patient about the difficulty parents have seeing their children turn out differently than expected. The patient explained that she was so distracted by her guilt and anxiety over the situation that she was unable to function as usual at work or at home. The consultant attempted to restore Ms. C's usual obsessive-compulsive defenses by suggesting that she establish a structured routine at home so that she could accomplish all her usual household duties. He pointed out that staying busy would help Ms. C take her mind off her daughter. Ms. C complied with this suggestion and seemed somewhat improved at the next session. During this meeting the psychiatrist pointed out that Ms. C talked as though her daughter's pregnancy was her own responsibility. The patient responded, "You mean I didn't spread her legs?" The doctor affirmed, "That's right. You didn't spread her legs." The patient experienced a flood of relief with the doctor's words and thanked him for relieving her guilt. She called the following week and said that she need not return because she felt "100% better."

In this example the psychiatrist first helped the patient restore adaptive defenses by encouraging a return to her usual schedule. He then used the patient's positive transference to absolve her of guilt. This absolution, coming as it did from an authority figure whom she regarded with respect, if not idealization, had much greater impact on her than it would have had if she had merely told herself the same message.

Long-Term Versus Brief Psychotherapy

Determining whether to prescribe long-term or brief psychotherapy is a complex decision. Clearly, the presence or absence of a focal issue is of considerable relevance (Ursano and Dressler 1974). If the patient's complaint is

sufficiently circumscribed, a recommendation for brief psychotherapy can result in less expense and less inconvenience for the patient. Also, in one study of dropout rate in a public mental health clinic, the assignment of a specified length of therapy at the outset of treatment resulted in one-half the dropout rate compared with patients without such a clear end point (Sledge et al. 1990). However, complicated characterological problems may interfere with a patient's effective implementation of any "quick-fix" approach. In an era in which length of therapy is often determined by third- or fourth-party payers based on cost considerations, therapists must be mindful that less is not necessarily better. In a rigorous analysis of the dose–effect relationship with psychotherapy, there was clearly a positive relationship between the amount of treatment and the amount of patient benefit (Howard et al. 1986).

Finally, there is always a danger of therapists prescribing what they think the patient needs rather than what the patient wants. Is the patient asking for a fundamental examination and restructuring of personality, or is the request limited to assistance with one specific problem or complaint? The patient must clearly be a collaborator in determining the kind of treatment. We would be well advised to remember the dictum—attributed to Freud—that in some way, the patient is always right.

Efficacy of Psychotherapy

The efficacy of individual psychotherapy is no longer in question. There is now overwhelming evidence that psychotherapy is an effective treatment (Luborsky et al. 1975; Shedler 2010; Smith et al. 1980). In fact, research shows that the magnitude of change brought about by psychotherapy is at a level that would justify the interruption of a clinical trial on the grounds that it would be unethical to withhold such a highly effective treatment from patients (Ursano and Silberman 1994). A meta-analysis of the efficacy of brief dynamic psychotherapy (Crits-Christoph 1992) found that the average brief dynamic therapy patient was better off than 86% of waiting-list control patients when target symptoms were examined. In another meta-analysis, Anderson and Lambert (1995) found that brief dynamic treatments "outperformed alternative treatments at follow-up assessment when measures of personality were used or when assessment took place 6 or more months posttreatment" (p. 512). Leichsenring et al. (2004) did a meta-analysis of short-term dynamic therapy studies between 1970 and 2004. They found no differences between brief dynamic therapy and cognitive-behavioral therapy in regard to changes in target problems, general psychiatric problems, and social functioning. Abbass et al. (2006) published a similar meta-analysis but compared brief dynamic therapy to minimal treatment

and nontreatment control subjects for adults with common mental disorders. Outcomes from most categories of disorders suggested significantly greater improvement that was maintained in the treatment groups versus the control groups.

Despite major obstacles, such as suitable controls, intervening life events, and extraordinary expense, to doing rigorous research on long-term dynamic therapy (Gunderson and Gabbard 1999), a growing body of research supports the value of long-term psychodynamic therapy. Leichsenring and Rabung (2008) conducted a meta-analysis of the effectiveness of long-term dynamic therapy. The results showed significantly higher outcomes and overall effectiveness for target problems and personality functioning when long-term dynamic therapy was compared with shorter forms of psychotherapy. Leichsenring and Rabung concluded that for more difficult to treat patients with greater comorbidity and more complexity, extended dynamic therapy may be the best choice. Shedler (2010) noted that as a result of a number of recent contributions to the research literature, we can now say that empirical evidence supports the efficacy of psychodynamic psychotherapy. He noted that the effect sizes of dynamic therapy are as large as those reported for other therapies that are often promoted as "evidence based." In addition, he pointed out that patients who receive psychodynamic treatment maintain therapeutic gains and often continue to improve after treatment has ended when follow-up measures are included in the research. Psychodynamic therapy appears to have an "extended-release" effect in that it sets in motion an ongoing internal process of self-reflection. In the subsequent chapters in this text, various studies will be reviewed as applied to specific disorders.

Randomized controlled trials are often criticized because the patients are highly selected, lack comorbidity, and are treated in a highly sophisticated context that does not correlate with what happens in the "real world." Two different studies—one in the United States conducted by *Consumer Reports* ("Mental Health: Does Therapy Help?" 1995) and one in Germany using a similar design (Hartmann and Zepf 2003)—attempted to measure the benefits of psychotherapy in a naturalistic setting. A questionnaire was distributed to patients who had been in psychotherapy to allow them to estimate their condition before and after treatment. In both studies, long-term psychotherapy produced significantly more improvements than short-term therapy, and there was a close relationship between duration of treatment and rate of improvement. As noted previously, there are relatively narrow indications for brief therapy, and most patients require more than a brief intervention.

To be sure, much more research needs to be conducted on long-term psychodynamic psychotherapy (Gabbard et al. 2002). Specifically, controlled

trials that are disorder specific are badly needed. Although such trials are common in the brief cognitive therapy literature, psychodynamic researchers have been slow to catch up. Research is also badly needed to identify clear indications and contraindications for long-term psychodynamic therapy, to define the features that distinguish a psychodynamic approach from other methods, and to test which types of patients will ultimately benefit from such treatment (Gunderson and Gabbard 1999).

References

Abbass AA, Hancock JT, Henderson J, et al: Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database of Systematic Reviews 2006, Issue 4. Art. No.: CD004687. DOI: 10.1002/14651858.CD004687.pub3

Adler G: The myth of the alliance with borderline patients. Am J Psychiatry 47:642–645, 1979

Amini F, Lewis T, Lannon R, et al: Affect, attachment, memory: contributions toward psychobiologic integration. Psychiatry 59:213–239, 1996

Anderson EM, Lambert MJ: Short-term dynamically oriented psychotherapy: a review and meta-analysis. Clin Psychol Rev 15:503–514, 1995

Aron L: Self-reflexivity and the therapeutic action of psychoanalysis. Paper presented at the annual meeting of the American Psychoanalytic Association, Toronto, Ontario, Canada, May 1998

Bachrach HM, Leaff LA: "Analyzability": a systematic review of the clinical and quantitative literature. J Am Psychoanal Assoc 26:881–920, 1978

Baekeland F, Lundwall L: Dropping out of treatment: a critical review. Psychol Bull 82:738–783, 1975

Basch MF: Doing Psychotherapy. New York, Basic Books, 1980

Beck NC, Lambert J, Gamachei M, et al: Situational factors and behavioral self-predictions in the identification of clients at high risk to drop out of psychotherapy. J Clin Psychol 43:511–520, 1987

Blagys MD, Hilsenroth MJ: Distinctive features of short term psychodynamic interpersonal psychotherapy: a review of the comparative psychotherapy process literature. Clin Psychol 7:167–188, 2000

Blatt SJ: The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patients: the Menninger Psychotherapy Research Project revisited. J Am Psychoanal Assoc 40:691–724, 1992

Blatt S: Experiences of Depression. Washington, DC, American Psychological Association, 2004

Book HE: How to Practice Brief Psychodynamic Psychotherapy: The Core Conflictual Relationship Theme Method. Washington, DC, American Psychological Association, 1998

Bordin ES: The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research, and Practice 16:252–260, 1979

Budman SH (ed): Forms of Brief Therapy. New York, Guilford, 1981

Busch F: The Ego at the Center of Clinical Technique (Critical Issues in Psychoanalysis 1). Northvale, NJ, Jason Aronson, 1995

Cabaniss DL, Cherry S, Douglas CJ, et al: Psychodynamic Psychotherapy: A Clinical Manual. Hoboken, NJ, Wiley-Blackwell, 2011

Chessick RD: What is intensive psychotherapy? Am J Psychother 35:489–501, 1981

Cooper AM: Psychic change: development in the theory of psychoanalytic techniques. Int J Psychoanal 73:245–250, 1992

Crits-Christoph P: The efficacy of brief dynamic psychotherapy: a meta-analysis. Am J Psychiatry 149:151–158, 1992

Davanloo H (ed): Short-Term Dynamic Psychotherapy. New York, Jason Aronson, 1980

Dewald PA: Psychotherapy: A Dynamic Approach, 2nd Edition. New York, Basic Books, 1971

Dewan MJ, Steenbarger BN, Greenberg RP (eds): The Art and Science of Brief Psychotherapies: A Practitioner's Guide. Washington, DC, American Psychiatric Publishing, 2004

Diener MJ, Hilsenroth MJ, Weinberger J: Therapists affect focus and patient outcomes in psychodynamic psychotherapy: a meta-analysis. Am J Psychiatry 164:936–941, 2007

Flückiger C, Del Re AC, Wampold BE, et al: How central is the alliance in psychotherapy? A multi-level longitudinal meta-analysis. J Couns Psychol 59:10–17, 2012

Fonagy P: The process of change, and the change of processes: what can change in a "good" analysis? Keynote address at the spring meeting of Division 39 of the American Psychological Association, New York, April 1999

Fonagy P: Attachment Theory and Psychoanalysis. New York, Other Press, 2001

Freud A: The ego and the mechanisms of defense (1936), in The Writings of Anna Freud, Vol 2, Revised Edition. New York, International Universities Press, 1966

Freud S: The interpretation of dreams (1900), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vols 4, 5. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 1–627

Freud S: Recommendations to physicians practising psycho-analysis (1912), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 109–120

Freud S: On beginning the treatment (1913), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 121–144

Friedman L: A reading of Freud's papers on technique. Psychoanal Q 60:564–595, 1991

Frieswyk SH, Allen JG, Colson DB, et al: Therapeutic alliance: its place as a process and outcome variable in dynamic psychotherapy research. J Consult Clin Psychol 54:32–38, 1986

Gabbard GO: Countertransference: the emerging common ground. Int J Psychoanal 76:475–485, 1995

Gabbard GO: Love and Hate in the Analytic Setting. Northvale, NJ, Jason Aronson, 1996

Gabbard GO: A reconsideration of objectivity in the analyst. Int J Psychoanal 78:15–26, 1997

Gabbard GO: Long-Term Psychodynamic Psychotherapy: A Basic Text, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2010

Gabbard GO, Lester EP: Boundaries and Boundary Violations in Psychoanalysis. Washington, DC, American Psychiatric Publishing, 2003

Gabbard GO, Westen D: Rethinking therapeutic action. Int J Psychoanal 84:823–841, 2003

Gabbard GO, Wilkinson SM: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press, 1994

Gabbard GO, Gunderson JG, Fonagy P: The place of psychoanalytic treatments within psychiatry. Arch Gen Psychiatry 59:505–510, 2002

Garfield SL: The Practice of Brief Psychotherapy. New York, Wiley, 1998

Greenberg JR: Theoretical models and the analyst's neutrality. Contemporary Psychoanalysis 22:87–106, 1986

Greenson RR: The Technique and Practice of Psychoanalysis. New York, International Universities Press, 1967

Greenson RR: The working alliance and the transference neurosis (1965), in Explorations in Psychoanalysis. New York, International Universities Press, 1978, pp 119–224

Grinberg L: The closing phase of the psychoanalytic treatment of adults and the goals of psychoanalysis: "the search for truth about one's self." Int J Psychoanal 61:25–37, 1980

Gunderson JG, Gabbard GO: Making the case for psychoanalytic therapies in the current psychiatric environment. J Am Psychoanal Assoc 47:679–703, 1999

Gustafson JP: An integration of brief dynamic psychotherapy. Am J Psychiatry 141: 935–944, 1984

Gustafson JP: The Complex Secret of Brief Psychotherapy. New York, WW Norton, 1986

Gutheil T, Gabbard GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 155:409–414, 1998

Hartley DE, Strupp HH: The therapeutic alliance: its relationship to outcome in brief psychotherapy, in Empirical Studies of Psychoanalytic Theories, Vol 1. Edited by Masling J. Hillsdale, NJ, Analytic Press, 1983, pp 1–37

Hartmann S, Zepf S: Defectiveness of psychotherapy in Germany: a replication of the Consumer Reports study. Psychother Res 13:235–242, 2003

Hoffman IZ: Ritual and Spontaneity in the Psychoanalytic Process: A Dialectical-Constructivist View. Hillsdale, NJ, Analytic Press, 1998

Hoffman IZ, Gill MM: Critical reflections on a coding scheme. Int J Psychoanal 69: 55–64, 1988

Høglend P: Long-term effects of brief dynamic therapy. Psychother Res 13:271–290, 2003

Høglend P, Amlo S, Marble A, et al: Analysis of the patient-therapist relationship in dynamic psychotherapy: an experimental study of transference interpretations. Am J Psychiatry 163:1739–1746, 2006

Høglend P, Hersoug AG, Bogwald KP, et al: Effects of transference work in the context of therapeutic alliance and quality of object relations. J Consult Clin Psychol 79:697–706, 2011

Horowitz MJ, Marmar C, Krupnick J, et al: Personality Styles and Brief Psychotherapy. New York, Basic Books, 1984a

Horowitz MJ, Marmar C, Weiss DS, et al: Brief psychotherapy of bereavement reactions: the relationship of process to outcome. Arch Gen Psychiatry 41:438–448, 1984b

Horvath AD, Symonds BD: Relation between working alliance and outcome in psychotherapy: a meta-analysis. J Couns Psychol 38:139–149, 1991

Horwitz L: Clinical Prediction in Psychotherapy. New York, Jason Aronson, 1974

Horwitz L, Gabbard GO, Allen JG, et al: Borderline Personality Disorder: Tailoring the Psychotherapy to the Patient. Washington, DC, American Psychiatric Press, 1996

Howard KI, Kopts SM, Krause MS, et al: The dose-effect relationship in psychotherapy. Am Psychol 41:159–164, 1986

Jacobs TJ: The corrective emotional experience: its place in current technique. Psychoanalytic Inquiry 10:433–454, 1990

Karasu TB: Psychotherapies: an overview. Am J Psychiatry 134:851–863, 1977

Killingmo B: Affirmation in psychoanalysis. Int J Psychoanal 76:503–518, 1995

Kohut H: How Does Analysis Cure? Edited by Goldberg A. Chicago, IL, University of Chicago Press, 1984

Lawson DM, Brossart DF: Link among therapies and parent relationship, working alliance, and therapy outcome. Psychother Res 13:383–394, 2003

Leichsenring F, Rabung S: Effectiveness of long term psychodynamic psychotherapy: A meta-analysis. JAMA 300:1551–1565, 2008

Leichsenring F, Rabung S, Leiding E: The efficacy of short term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. Arch Gen Psychiatry 61:1208–1216, 2004

Lipton SD: The advantages of Freud's technique as shown in his analysis of the Rat Man. Int J Psychoanal 58:255–273, 1977

Loewald HW: On the therapeutic action of psychoanalysis (1957), in Papers on Psychoanalysis. New Haven, CT, Yale University Press, 1980, pp 221–256

Lohser B, Newton PM: Unorthodox Freud: The View From the Couch. New York, Guilford, 1996

Luborsky L: Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment. New York, Basic Books, 1984

Luborsky L, Singer B, Luborsky L: Comparative studies of psychotherapies: is it true that "everyone has won and all must have prizes?" Arch Gen Psychiatry 32:995–1008, 1975

Luborsky L, Mintz J, Auerbach A, et al: Predicting the outcome of psychotherapy: findings of the Penn Psychotherapy Project. Arch Gen Psychiatry 37:471–481, 1980

Luborsky L, Crits-Christoph P, Mitz J, et al: Who Will Benefit From Psychotherapy? Predicting Therapeutic Outcomes. New York, Basic Books, 1988

Lyons-Ruth K, Members of the Change Process Study Group: Implicit relational knowing: its role in development and psychoanalytic treatment. Infant Ment Health J 19:282–289, 1998

MacKenzie KR: Recent developments in brief psychotherapy. Hosp Community Psychiatry 39:742–752, 1988

Malan DH: The Frontier of Brief Psychotherapy: An Example of the Convergence of Research and Clinical Practice. New York, Plenum, 1976

Malan DH: Toward the Validation of Dynamic Psychotherapy: A Replication. New York, Plenum, 1980

Mann J: Time-Limited Psychotherapy. Cambridge, MA, Harvard University Press, 1973

Martin DJ, Garske JP, Davis KK: Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. J Consult Clin Psychol 68:438–450, 2000

Marziali E, Marmar C, Krupnick J: Therapeutic alliance scales: development and relationship to psychotherapy outcome. Am J Psychiatry 138:361–364, 1981

McWilliams N: Psychoanalytic Psychotherapy. New York, Guilford, 2004

Menninger KA: Theory of Psychoanalytic Technique. New York, Basic Books, 1958

Mental health: does therapy help? Consumer Reports, November 1995, pp 734–739

Mitchell SA: Influence and Autonomy in Psychoanalysis. Hillsdale, NJ, Analytic Press, 1997

Morgan R, Luborsky L, Crits-Christoph P, et al: Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. Arch Gen Psychiatry 39: 397–402, 1982

Ornstein A: "Supportive" psychotherapy: a contemporary view. Clin Soc Work J 14: 14–30, 1986

Perry JC, Bond M: Change in defense mechanisms during long-term dynamic psychotherapy and a five year outcome. Am J Psychiatry 169:916–925, 2012

Pine F: On therapeutic change: perspectives from a parent-child model. Psychoanalysis and Contemporary Science 5:537–569, 1976

Pine F: Supportive psychotherapy: a psychoanalytic perspective. Psychiatric Annals 16:526–529, 1986

Pine F: Diversity and Direction in Psychoanalytic Technique. New Haven, CT, Yale University Press, 1998

Piper WE, Azim HFA, McCallum M, et al: Patient suitability and outcome in short-term individual psychotherapy. J Consult Clin Psychol 58:475–481, 1990

Pulver SE: Psychic change: insight or relationship? Int J Psychoanal 73:199–208, 1992

Racker H: Transference and Counter-transference. New York, International Universities Press, 1968

Renik O: Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. Psychoanal Q 62:553–571, 1993

Roskin G: Changing modes of psychotherapy. Journal of Psychiatric Treatment and Evaluation 4:483–487, 1982

Roth S: Psychotherapy: The Art of Wooing Nature. Northvale, NJ, Jason Aronson, 1987

Sandler J: Countertransference and role-responsiveness. International Review of Psychoanalysis 3:43–47, 1976

Scheidt CE, Burger T, Strukely S, et al: Treatment selection in private practice psychodynamic psychotherapy: a naturalistic prospective longitudinal study. Psychother Res 13:293–305, 2003

Shedler J: The efficacy of psychodynamic psychotherapy. Am Psychol 63:98–109, 2010

Sifneos PE: Short-Term Psychotherapy and Emotional Crisis. Cambridge, MA, Harvard University Press, 1972

Sledge WH, Moras K, Hartley D, et al: Effect of time-limited psychotherapy on patient dropout rates. Am J Psychiatry 147:1341–1347, 1990

Smith ML, Glass GV, Miller TI: The Benefits of Psychotherapy. Baltimore, MD, Johns Hopkins University Press, 1980

Steiner J: The aim of psychoanalysis. Psychoanal Psychother 4:109–120, 1989

Stern DN, Sander LW, Nahum JP, et al: Non-interpretive mechanisms in psychoanalytic therapy: the "something more" than interpretation. Int J Psychoanal 79: 903–921, 1998

Summers RF, Barber JP: Psychodynamic Therapy: A Guide to Evidence-Based Practice. New York, Guilford, 2009

Ursano RJ, Dressler DM: Brief versus long-term psychotherapy: a treatment decision. J Nerv Ment Dis 159:164–171, 1974

Ursano RJ, Hales RE: A review of brief individual psychotherapies. Am J Psychiatry 143:1507–1517, 1986

Ursano RJ, Silberman EK: Psychoanalysis, psychoanalytic psychotherapy, and supportive psychotherapy, in The American Psychiatric Press Textbook of Psychiatry, 2nd Edition. Edited by Hales RE, Yudofsky SC, Talbott J. Washington, DC, American Psychiatric Press, 1994, pp 1035–1060

Vaslamatzis G, Markidis M, Katsouyanni K: Study of the patients' difficulties in ending brief psychoanalytic psychotherapy. Psychother Psychosom 52:173–178, 1989

Wallerstein RS: Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy. New York, Guilford, 1986

Werman DS: The use of dreams in psychotherapy: practical guidelines. Can Psychiatr Assoc J 23:153–158, 1978

Werman DS: The Practice of Supportive Psychotherapy. New York, Brunner/Mazel, 1984

Westen D, Gabbard GO: Developments in cognitive neuroscience, II: implications for theories of transference. J Am Psychoanal Assoc 50:99–134, 2002

Winnicott DW: The aims of psychoanalytic treatment (1962), in The Maturational Processes and the Facilitating Environment. London, Hogarth, 1976, pp 166–170

Winston A, Muran C: Common factors in the time-limited therapies, in American Psychiatric Press Review of Psychiatry, Vol 15. Edited by Dickstein LJ, Riba MB, Oldham JM. Washington, DC, American Psychiatric Press, 1996, pp 43–68

Winston A, Rosenthal R, Winston E: Supportive Psychotherapy. Washington, DC, American Psychiatric Publishing, 2004

CHAPTER 5

TREATMENTS IN DYNAMIC PSYCHIATRY

Group Therapy, Family/Marital Therapy, and Pharmacotherapy

Dynamic Group Psychotherapy

We all live and work in the context of groups. Group psychotherapy provides patients an opportunity to learn how they function in groups—the roles they play, the expectations and unconscious fantasies they harbor about groups, and the obstacles they encounter in getting along with others at work and at home. Unique dimensions of group experience can be only partially explored in individual psychotherapy. In particular, the sociopsychological context in which the group occurs is not available in one-to-one therapy (Rutan and Stone 2001).

Unique Aspects of Group Experience

Much of our knowledge of the forces operating in groups is derived from the work of Wilfred Bion (1961). After World War I, Bion began conducting small group experiences at the Tavistock Clinic. His understanding of groups revolved around his observation that two subgroups are present in every group: 1) the "work group" and 2) the "basic assumption group." The former is involved with the actual work task of a group and is geared toward com-

pletion of the task. Few groups, however, work rationally toward attaining their goals without interference from basic assumptions (Rioch 1970).

Basic assumptions refer to the unconscious fantasies that lead groups to behave in an "as-if manner" (Rioch 1970). In other words, the group members begin to act on an assumption about the group that is different from the reality of the task at hand. Basic assumptions fall into three categories: dependency, fight/flight, and pairing. These discrete emotional states are unconscious in origin but are easily deducible from the behavior of the group. These assumptions derail the work group and prevent completion of its task. In a psychotherapy group, the task of understanding one another's problems may be steered off course by the development of basic assumptions. However, just as Freud discovered that transference in psychoanalysis is more of a therapeutic tool than an obstacle, Bion discovered that the basic assumptions themselves can be of enormous value in helping individual members of groups understand themselves in the context of the group.

Bion's initial observations of basic assumptions were at a descriptive level, but as he gained more and more experience with group dynamics, he realized that the basic assumptions were clusters of defenses against psychotic anxieties present in everyone. Groups are powerfully regressive, and they provide patients with a window into their most primitive fears. Bion realized that the mechanisms associated with the paranoid-schizoid and depressive positions identified by Melanie Klein (see Chapter 2) were also present in the basic assumptions.

The dependency basic assumption, for example, can be viewed as a cluster of defenses against depressive anxieties (Ganzarain 1980). In this basic assumption, patients behave as though they are weak, ignorant, and incapable of helping each other and as though they are totally dependent on the therapist, whom they view as godlike. The underlying fear is that their greed (i.e., their oral neediness) will engulf the therapist and result in their being abandoned. To defend against the anxiety and guilt connected with their potential destruction of the therapist (i.e., their mother at an unconscious level), the patients believe that the therapist is an inexhaustible, omniscient, and omnipotent figure who will always be there for them and who will always have the answers.

In the fight/flight basic assumption, the group has regressed to a frank paranoid-schizoid position. All "badness" is split off and projected. The wish to fight or take flight is a cluster of defenses against paranoid anxiety. To avoid an externally perceived persecutor who will destroy them, the group can either fight or run from the persecutor. The group becomes nonreflective and views action as the only solution to the perceived threat.

The pairing basic assumption is a cluster of defenses against depressive anxieties. The assumption in this instance frequently revolves around two

group members who will reproduce and bring forth a messiah to rescue the group (Rioch 1970). There is a pervasive atmosphere of optimism and hopefulness, a belief that love will prevail. This Pollyannaish attitude may be viewed as a manic defense against the group's concern that destructiveness, hate, and hostility also exist within the group. Hence, in this view pairing can be viewed as a manic reparative effort (Ganzarain 1980).

Group psychotherapists must be continually vigilant for the development of basic assumptions in their groups so that they can interpret and examine them before they become too destructive to the task of the group. Unexamined transference may lead an individual to quit psychotherapy; unexamined basic assumptions may lead to the dissolution of group therapy.

Beyond the basic assumptions, there are other unique forces operating in groups. Emotional contagion occurs when intense emotions spread throughout a group almost instantaneously (Rutan and Stone 2001).We all may find feelings of sadness, anger, or hilarity irresistible in the context of a group. Another powerful force is the phenomenon of "role suction" (Redl 1963). It is commonly observed that an individual's behavior in a one-to-one situation may change dramatically upon entry to a group, for example, the "good boy" who "gets in with the wrong crowd." Individuals who find themselves behaving differently in groups often describe themselves as being drawn or "sucked" into playing a role that seems outside their control. An individual patient in group psychotherapy may serve as a spokesperson for the entire group, while everyone else remains silent. Another individual may serve in the role of scapegoat, behaving in such a way as to become the target for everyone's anger. Both the spokesperson and the scapegoat phenomena can be understood as group versions of projective identification (Horwitz 1983; Ogden 1982). In scapegoating, for example, the unacceptable parts of all the group members are projected onto one individual who then feels coerced into responding like the projected parts of the other patients. If the therapist supports the scapegoat and interprets the group process, the projected parts may be reintrojected.

Characteristics of Psychotherapeutic Groups

Most group therapists meet with their groups once a week (Rutan and Stone 2001), although some may meet twice a week. The duration varies from 75 to 125 minutes, and the average dynamic psychotherapy group contains 6–10 members (Rutan and Stone 2001; Sadock 1983). Smaller groups may be viable if the members are actively participatory.

The composition of a dynamic therapy group may vary considerably, although heterogeneous groups are thought to have advantages over homogeneous groups (Yalom 1985). The consensus of clinicians is that groups in

which everyone is similar rarely get beyond superficial levels of interaction. On the other hand, if a group is too heterogeneous, it may be dysfunctional because of the lack of common ground among the patients. Moreover, certain individuals may feel isolated if they believe that they are vastly different from everyone else in the group by virtue of their age, cultural background, or socioeconomic status. Finally, if members of the group have highly variable levels of ego strength, the group may not gel because of the difficulty in exploring psychological issues.

The consensus of the literature is that dynamic therapy groups should be heterogeneous in terms of the conflicts of the members but homogeneous in terms of a reasonably similar level of ego strength (Whitaker and Lieberman 1964; Yalom 1985). Most of the dynamic group psychotherapy literature is weighted toward the expressive end of the expressive-supportive continuum. Groups that are more supportive in nature may be more homogeneous as well. Dynamic therapy groups are typically open-ended, and new members may be added as old members terminate.

In recent years, with the pressures of managed care and accountability in the health care environment, briefer versions of group psychotherapy have become more prevalent, even for heterogeneous groups. MacKenzie (1997) developed a concept of time-managed group psychotherapy in which he delineated three models of group psychotherapy based on patient need and awareness of limitations on resources available for treatment: 1) crisis intervention (1–8 sessions), 2) time-limited therapy (8–26 sessions), and 3) longer-term therapy (more than 26 sessions). Empirical research has begun to support the efficacy of briefer forms of dynamic group therapy. In one study of 12-week expressive therapy groups for outpatients who had not adapted well to loss (Piper et al. 1992), treated patients showed greater improvement than waiting-list control patients, and their improvements were maintained or even increased at 6-month follow-up.

Dynamic group psychotherapists vary in the extent to which they use a group-centered versus an individual-centered approach. The more extreme advocates of the group-centered approach (Ezriel 1950) have viewed the interpretation of group forces as much more important than the interpretation of the individual's conflicts. In fact, Ezriel (1950) suggested that the therapist should refrain from interpretation until a common group tension or theme has developed. A less extreme approach was advocated by Horwitz (1977), who proposed that individual interpretations may be used in the service of building up the group's awareness of a common group issue, which is then also interpreted. There are common group experiences that everyone shares and that deserve interpretation, such as not having all one's needs met by the leader, competition for support, and anxiety about being ignored. However, if there is no focus on individual issues as well, patients may feel

that their individual reasons for seeking treatment have been overlooked by the therapist. Most group therapists subscribe to a combined model involving both individual- and group-centered interventions (Slipp 1988).

Transference, Countertransference, Resistance, and Group Alliance

Transference, countertransference, and resistance are cornerstones of dynamic group psychotherapy, just as they are in individual work. However, the group modality itself significantly alters the transference. First, the intensity of the patients' transferences may be diluted by their redirection to fellow patients. Group psychotherapy allows for the formation of multiple simultaneous transferences. The therapist then is provided with a laboratory in which the patients' internal object relations are displayed for all to see through externalization in relationships with individual group members. Although different transferences develop in individual therapy as well, they tend to appear over a longer period. The group setting may allow the therapist to gain a greater familiarity with the patients' internal object relations in a much shorter time.

Although transference may be diluted in group therapy, the converse is also true. Transference may be intensified when the entire group is swept up with powerful feelings of either positive or negative valence. Therapists who serve as containers for all the bad object projections in the group members rapidly realize that countertransference may also be intensified in a group setting. The countertransferential demands on the group therapist may be formidable. Fortunately, there is built-in protection against untoward countertransference acting-out, because group patients will readily spot inappropriate behavior or misperceptions on the part of the therapist. To diffuse transference and countertransference, some therapists prefer to work with a co-therapist in group psychotherapy. Having a partner helps the therapist to process the intense feelings stirred up by the group.

Sibling rivalry and a transference wish to be the therapist's only or favorite child are common developments in all dynamic therapies. However, these issues may have a more compelling quality in group therapy, and the therapist must diligently avoid showing any favoritism for specific group members (Yalom 1985).

In addition to the patients' transference to the therapist and to other group members, there is a third form of transference that is truly unique to groups: transference to the group as a whole. This form of transference affords patients an opportunity to examine their expectations of other groups within which they live and work. The group as a total entity is often viewed as an idealized, completely gratifying "mother" that will satisfy the patient's yearning for a reunion with an unconditionally loving figure. In recognition

of this tendency, Scheidlinger (1974) dubbed this phenomenon the "mother-group." When this form of transference is in full flower, the therapist may be viewed as a terrifying maternal figure in contrast to the all-giving benevolence of the group as a whole. Other authors (Gibbard and Hartman 1973) have viewed the idealized transference to the group as a whole as a defensive posture that avoids seeing the group (mother) as sadistic.

Just as therapeutic alliance may be predictive of success in individual therapy, group alliance may augur well for a good outcome in group psychotherapy. In fact, patients in group therapy tend to place greater importance on relationship-climate factors than do patients in individual therapy (Holmes and Kivlighan 2000). Although group alliance is more elusive to define than therapeutic alliance in individual psychotherapy, it is generally regarded as the active collaboration on therapeutic goals that occurs between members and therapist, between members themselves, and between members and the group as a whole (Gillaspy et al. 2002). Preliminary data suggest that group alliance may be the best predictor of good outcome in group therapy for substance-abusing patients in a residential treatment program (Gillaspy et al. 2002). In a more recent study (Lo Coco et al. 2012), the therapeutic alliance was assessed in 32 patients in heterogeneous psychodynamic groups. The investigators found that a patient's symptom reduction was greater when there was agreement between the group member and the other group patients that their alliance to the group as a whole was strong.

The working through of transference and resistance constitutes the bulk of the dynamic therapist's task, much as it does in individual psychotherapy. Indeed, Ganzarain (1983) suggested that working through is the key characteristic that distinguishes psychoanalytic group therapy from other forms of group treatment. He particularly emphasized the working through of primitive psychotic-like anxieties and their associated defense mechanisms. The regressive forces activated by group experience bring the patient in touch with anxiety stemming from the paranoid-schizoid and depressive positions much more rapidly and more profoundly than in individual treatment. The working through of transference is also facilitated by the input of other group members. An individual patient may attempt to validate a personal impression of the therapist by "checking it out" with other group patients. When peers, rather than the therapist, confront the distortions inherent in the transference perception, the patient may be much more willing to listen and accept feedback.

Indications and Contraindications

A number of indications for dynamic group psychotherapy are the same as those for expressive-supportive individual therapy. These include 1) strong

motivation, 2) psychological mindedness, 3) a reasonably high level of ego strength, 4) sufficient discomfort that the patient is willing to endure the frustrations inherent in the process, and 5) problems in interpersonal relationships (Yalom 1985). However, the question that the clinician must address is: What specific criteria suggest that a patient is particularly suited for group psychotherapy rather than individual psychotherapy?

There has been an unfortunate tradition in the field to view group psychotherapy as a second-class treatment modality. Review articles comparing individual and group psychotherapy do not support this bias (Lambert and Bergin 1994; MacKenzie 1996). Most of these comparison studies find no difference in outcome. Dynamic group therapy is probably an underused modality despite its attractiveness in terms of cost effectiveness. Outpatient group psychotherapy may be a particularly useful way to sustain treatment gains made by those with personality disorders after discharge from day treatment (Bateman and Fonagy 2001; Wilberg et al. 2003). In some cases further improvements are noted in the postdischarge group treatment of such patients.

Several kinds of problems may be dealt with more effectively in a group setting than in individual treatment (Sadock 1983). The patient who is extraordinarily anxious around authority figures may find it easier to talk and relate in the company of peers. A patient whose primary problem seems to have originated in sibling conflicts may find that a group setting reactivates the problem in a way that makes it easier to examine and resolve. Conversely, sometimes an only child who missed out on a sibling experience and who has difficulty learning to share in adult life may find that a group is the best place to address those issues. Nonpsychotic patients who rely heavily on projection may benefit from the confrontations of other group members, who repeatedly dispute the distortions brought to the group. Borderline patients who form an intensely negative transference in individual therapy may benefit from the dilution of transference inherent in group work. However, these patients almost always require individual therapy as well (see Chapter 15). When the two modalities are combined, there are additive and magnifying effects for both the individual and the group treatment (Porter 1993; Sperry et al. 1996). The additive effects of individual therapy include deep intrapsychic exploration and one-to-one corrective emotional experience. The additive effects of group therapy are the exploration of multiple transferences and the provision of a setting in which the patient can risk new behaviors. One of the magnifying effects of individual therapy is that it may provide an opportunity to explore material developing from the group sessions and thus may prevent premature dropout from the group. A possible magnifying effect of the group therapy is an additional chance to analyze transference resistances from the individual sessions.

Group therapy is generally effective for patients with personality disorders, including hysterical, obsessive-compulsive, and some borderline and narcissistic, passive-aggressive, and dependent types, because a group setting may be the only place in which these patients receive feedback about how their character patterns affect others. Much of the psychopathology found in patients with personality disorders involves ego-syntonic character traits (i.e., behaviors that distress others but not the patient). The feedback from peers in group therapy often helps these patients reflect on their behavior patterns so that these traits eventually become ego-dystonic (i.e., uncomfortable to the patients themselves), which is the first step toward gaining sufficient motivation to change. The effect of group psychotherapy on particular personality disorders and the indications for combined individual and group therapy are further addressed in Section II of this volume.

One obvious difference between individual and group psychotherapy in assessing indications is that the group therapist must constantly evaluate the fit between a prospective patient and the group as it is currently composed. One borderline patient may be quite tolerable in a group of patients with a high level of ego strength, but two may overwhelm the group with disproportionate demands for attention and disruptive acting-out. Similarly, issues such as age and gender must be balanced when deciding on indications for a particular group.

Certain clinical symptomatology is consensually viewed as contraindicating dynamic group psychotherapy. These features include 1) low motivation, 2) psychotic disorganization, 3) active addiction to substances, 4) antisocial personality disorder, 5) severe somatization, 6) organically based cognitive dysfunction, and 7) serious suicide risk (Yalom 1985). Addicted patients and patients with antisocial features may, however, be effectively treated in homogeneous groups of a confrontational nature (see Chapters 12 and 17). As is the case with indications, some patients may be contraindicated for a particular group because of the composition of that group, but they might instead be suitable for a different group. However, it is important to stress that research (Chapman et al. 2012) suggests that therapists underestimate the number of patients who will deteriorate during group therapy and are unable to accurately predict how patients will perceive the group relationship.

Family and Marital Therapy

Although many family and marital therapists practicing today are not dynamically oriented, the field had its origins in the work of a number of early psychoanalytically oriented clinicians, including Theodore Lidz, Lyman Wynne, Nathan Ackerman, Murray Bowen, and Virginia Satir. The focus of

these early family therapists on the psychology of the individual was dramatically altered in the decades of the 1950s and 1960s by a group of Palo Alto researchers, including Gregory Bateson, Don Jackson, and Jay Haley (Bateson et al. 1956). Systemic family therapy grew out of the work of this group, and with it the emphasis shifted from the individual to the family system. Individual psychopathology and personal history both became secondary to the family as a whole, which was viewed as a system with a life of its own. Until recently, this systemic approach to family therapy, along with its subsequent elaborations by Minuchin (1974) and Selvini Palazzoli et al. (1978), has largely dominated the field of family therapy.

Bowen family therapy is rooted in psychoanalytic theory, but the technique that has evolved from the ideas of Bowen (1978) is largely nondynamic. In this form of treatment, one individual family member meets with the therapist on an infrequent basis (often once a month) to carefully study the intergenerational patterns in the patient's family. The patient is helped to understand how the current patterns in family relationships are repetitions of patterns from past generations. The approach is strictly cognitive, and the patient is not encouraged to express feelings. Transference issues are not viewed as important and are not interpreted. On the contrary, once patients have gained an intellectual understanding of their family patterns, they are encouraged to address the unresolved issues directly with the appropriate family members.

Phenomena derived from psychoanalytic thinking, such as transference and countertransference, are recognized in a number of different models of family and marital therapy (Glick et al. 2000; Sholevar and Schwoeri 2003). Transferences may occur from one partner to the other, not only from patient to therapist. Moreover, the couple or family as a whole can develop intense transferences to the therapist. Analogous to group psychotherapy, the therapist may have countertransferences to the couple or family as a whole instead of to an individual patient.

Today object relations theory, as well as amalgams of object relations perspectives, self psychology, and intersubjective theory, forms the basis of most psychodynamic couples and family therapies. In this chapter we will examine some of the major approaches that use these concepts, particularly in therapies that are designed for couples and/or marital partners.

Theoretical Understanding

Working with married couples at the Tavistock Clinic in the 1950s and 1960s, Henry Dicks (1963) began to notice that relatively healthy couples—who appeared to have satisfying marriages—were often working out primitive object relationships in their marriages. He observed that each spouse

tended to perceive the other as though he or she were someone else. Typically, the husband would perceive the wife as though she were an internal object representation from his own psyche, often his own mother. Similarly, the wife would relate to the husband as though he were simply a projection from her internal world. Dicks concluded that a major source of marital discord was the failure of each partner to confirm the other's true nature or identity. Instead, the partners tended to coerce each other into behaving in highly stereotyped and constricting ways. Couples tended to deteriorate into polarized units, such as sadistic–masochistic, domineering–submissive, healthy–sick, and independent–dependent. Dicks recognized that each of these polarized halves formed a whole personality in the marital dyad, but that each individual alone was incomplete. Just as his colleague Bion was noting that groups exert a regressive force on individuals, Dicks was discovering that marriage has a similar regressive effect. Even in people with considerable ego strength, marriage seemed to regress them rapidly into parent–child relationships.

What Dicks observed, of course, was a form of transference. The marital partners were reenacting a past relationship in the present. In the language of object relations theory, the spouses were using splitting and projective identification to make an *internal* conflict an *external,* or marital, conflict, with an internal object representation, usually a parent, split off and projected onto the spouse. The projector then behaved in such a way as to coerce the spouse into behaving like the projected internal object. A husband, for example, who is used to being babied by his mother may unconsciously re-create the situation with his mother in his marriage by acting childish and evoking a motherly response from his wife. Alternatively, the marital partner may project a self representation onto the spouse and coerce the spouse into behaving like that self representation while the projector behaves like a complementary object representation. The case of Mr. B in Chapter 4 was such a situation. He projected a victimized, submissive self representation onto both his first and his second wife while behaving like his domineering, aggressive father.

Marital conflict may be viewed as the re-creation of conflicts with one's parents via splitting and projective identification. The selection of a mate is obviously much influenced by such processes. Dicks (1963) believed that such selections are "largely based on unconscious signals or cues by which the partners recognize in a more-or-less central ego-syntonic person the other's 'fitness' for joint working-through or repeating of still unresolved splits or conflicts inside each other's personalities, while at the same time, paradoxically, also sensing a guarantee that with that person they will not be worked-through" (p. 128). Hence, couples are thrown together by conflicting desires to work through unresolved object relations on the one hand and to simply repeat them on the other.

Several authors have expanded this object relations understanding of marital conflict to the entire family (Scharff and Scharff 1987; Shapiro et al. 1975; Slipp 1984, 1988; Stewart et al. 1975; Zinner and Shapiro 1972, 1974). These authors noted that the identified patient in a family is frequently a carrier or container of the split-off, unacceptable parts of other family members. In that sense, the family equilibrium is maintained by this arrangement of splitting and projective identification. An adolescent boy, for example, may act on antisocial impulses that represent aspects of an unacceptable self representation of his father that has been projectively disavowed by the father and contained by the son. A child may be idealized in the same way through projective identification of positive aspects of self or object representations. Object relations theory lends itself well to family therapy because its constructs (e.g., splitting and projective identification) provide a bridge from the intrapsychic to the interpersonal and from the individual to the family (Slipp 1984; Zinner 1976).

Technique

The technique of object relations therapy for couples and families grows out of the theoretical understanding. The overall goal is to help members of the family or couple reinternalize the conflicts that have been externalized through projective identification (Scharff and Scharff 1991; Zinner 1976). Practically speaking, this theoretical model must simultaneously help a couple address their real differences while examining the projections of each spouse so that each individual ultimately re-owns projected parts as an outcome of the therapy (Polonsky and Nadelson 2003). To accomplish this goal, the object relations therapist will typically meet with the family or couple for a 50-minute session every week or every other week (Slipp 1988).

The therapy process begins with a careful diagnosis of how internal self and object representations have been distributed throughout the family via splitting and projective identification. When this pattern becomes apparent, the therapist attempts to explain how an unconscious, collusive system is formed among family members to perpetuate pathological behavior in the identified patient. The stability of the family depends on the ability of one or more individual members to contain various projected parts of other family members. As with other forms of dynamic psychotherapy, these explanatory interpretations are usually met with resistance early on. This antitherapeutic force may take the form of attempting to get the therapist "sucked into" the family system. In other words, family members unconsciously repeat the family's pathological patterns instead of verbalizing and exploring them. In marital therapy, for example, a husband may use projective identification with the therapist in the same way he does with his spouse.

Because of these powerful resistances, object relations family therapists must be especially attuned to their countertransference reactions in the broad or objective sense. In other words, it is critically important that therapists allow themselves to be containers for the projected parts of the family members so that they can more adequately diagnose and interpret what happens within the family (Slipp 1988). Therapists are then in a position to point out the pathological collusive patterns in the here and now of the therapy process and to connect them with what goes on outside that process.

The most common form of resistance at the beginning of marital therapy is for both partners to expect the therapist to "fix" their spouse (Jones and Gabbard 1988). Because the externalization of the conflict onto the partner is so well established, both spouses are more interested in persuading the therapist that they are "right" than they are in repairing the marriage (Berkowitz 1984). Therapists must consistently avoid taking sides in such conflicts. Instead, they must help couples expand their perspective to encompass an appreciation of their own contributions to the conflict in the marriage.

The transition from seeing the problem as a marital conflict to perceiving it as an internal conflict played out within the couple is a difficult task for each partner. Projective identification in the marital dyad requires a continued state of conflict—the polarization inherent in the splitting process maintains the stable balance (Zinner 1976). Any effort to destabilize this arrangement is likely to be highly threatening to both marital partners. The need for the spouse to be the "bad object" may be so compelling that all therapeutic efforts are for naught (Dicks 1963). Despite their understanding of the pathological interactions between them, some couples will choose to live in a state of turmoil rather than face the anxiety associated with change.

In the final analysis, of course, change in marital therapy is not the therapist's responsibility—only the marital partners themselves can decide whether they wish to change their marriage. When therapists find themselves highly invested in a particular outcome, they are frequently involved in a collusive interaction in which they have become identified with projected parts of the family members. Moreover, the more the therapist pushes for change, the more the couple is likely to resist. Much resistance arises because an unconscious marital contract involving the behavior of both members of the couple or all family members is being challenged by the therapist's effort to alter the system. At times, this unspoken contract must be identified and laid bare for all participants in the process. When the therapy becomes stalemated because of such resistance, it is sometimes useful for the therapist to lay out various options to the couple and to convey to them that they are free to choose how to proceed with their lives. Divorce or no change at all must be among those options and must be considered ac-

ceptable outcomes by the therapist. Only then will the couple realize that it is ultimately up to them how they choose to live their lives.

Intersubjective and Self Psychological Marital Therapy

In recent years the concepts of self psychology have also been applied to marital conflict. Kohut (1984) himself, in a footnote from his last book, noted that "a good marriage is one in which one or the other partner rises to the challenge of providing the selfobject functions that the other's temporarily impaired self needs at a particular moment" (p. 220). He also noted that when selfobject needs are not supplied by a spouse, the result may be divorce and unending bitterness—a form of all-too-common chronic narcissistic rage.

Zeitner (2012) focuses on the vicissitudes of the self structure as it enters a partnership. In this regard he melds contributions of self psychology with those of contemporary object relations theory. His concept of the *selfdyad* is used to describe how two individual personalities become revised as they enter into a couple relationship system. This construct is unique to an individual couple and will not be replicated in future relationships. Noting that the selfdyad shares some functions with Kohut's notion of selfobject, Zeitner emphasizes that for the couple to remain intimate and stable, each partner requires a central affirmation from the other while also evolving through a series of progressive projective identifications in which each internalizes aspects of the other.

The conflicts arising from the need for selfobject responses by one's spouse can form the basis of a strategy for marital therapy (Ringstrom 1994, 1998, in press; Shaddock 1998). Ringstrom (1994) pointed out the importance of the bidimensional nature of transference in therapy with couples (see Chapter 1). Having been frustrated in their attempts to get their selfobject needs met from each other, the couple may be "locked in to reciprocally antagonistic, repetitive dimension transferences toward one another while each spouse is experiencing the yearned-for selfobject in the transference toward the therapist" (Ringstrom 1994, p. 161). Although this development may be problematic in some ways, the therapist's attunement to it may restore hope to the couple.

Ringstrom (2014) emphasizes three themes that are central to his understanding of the psychodynamics of couples: 1) the actualization of self-experience in the context of a long-term, committed intimate relationship; 2) mutual recognition of both partners' subjective experiences; and 3) the fact that the relationship ultimately has a mind of its own. With these themes in mind, he outlines a method operationalized in six steps for thinking about and practicing couples therapy from an intersubjective approach.

The therapist must first be attuned to each partner's subjectivity as a way of instilling hope, perspective, and renewed growth. A crucial aspect of the

therapy, which Ringstrom describes in step two, is the therapist's need to clarify that none of the three participants in the therapy process has a privileged or "correct" view of reality. Each perspective has its own form of legitimacy and validity. In the third step a developmental model is used to understand how each partner's childhood and adolescent history brings something unique to the relationship. In step four the therapist examines how the partners reenact their conflictual past in the service of remaining the same while also attempting to change. Dissociated self states become actualized through the treatment so they can be examined as well. Step five of this approach is to stress how each partner's capacity for self actualization can be enhanced with introspection in the presence of the other. Step six prepares the couple to engage in the intersubjective work of recognizing and negotiating one's sense of self in the other and coming to some compromise regarding their relational conflicts. A couple must also recognize that certain terms may be nonnegotiable. Ringstrom (2014) stresses that these steps suggest a more linear approach than what actually happens in practice. All six steps may emerge in one session.

Ringstrom also takes into account the attachment backgrounds of each member of the couple. Central to his model is an understanding of each partner's capacity to mentalize and to recognize themselves and others as centers of their own initiative. Failures to mentalize based on early traumatic experiences create difficult problems in the couple because of their incapacity for appreciating the validity of the partner's subjective view alongside the validity of the individual's own view.

Indications and Contraindications

The "consumer" model is a commonsense approach clinicians can use in deciding whether a patient needs individual or family/marital therapy. What is the patient asking for? Does one "patient" come to the office or do two? Does the discussion focus on "my problem" or "our problem"? Is the problem viewed as having an internal origin or an external one? If parents come with their adolescent child, the problem of determining the therapy of choice may be more complex. Frequently, the adolescent is not convinced of the need for treatment and may remain silent throughout most of the first appointment. Meanwhile, the parents may go on and on about their son's or daughter's problems. The evaluating clinician needs to make a rapid determination regarding the next appointment. Will seeing only one "patient" be a collusion with the splitting and projective identification processes in the family (Stewart et al. 1975)? When in doubt, of course, the clinician may simply continue an exploratory evaluation process until the dynamics of the family are clearer. At times when one member of a couple or certain family members

simply refuse to attend a therapy process, the therapist may be forced to work with only one family member or to do no treatment at all.

Slipp (1988) stressed the identified patient's level of differentiation from the family as a good rule of thumb in determining the therapy of choice. Individual psychotherapy is probably the treatment of choice with late adolescents or young adults who have managed to separate, psychologically and geographically, from their families and to live their own lives with reasonably mature defensive operations. However, family therapy or a combination of family and individual therapy is likely to be most helpful with individuals in the same age group who are still living at home or who are living separately but still find themselves emotionally involved with their families in an intense and conflictual manner.

A frequent problem that arises in individual psychotherapy is the patient's request to bring the spouse to an appointment to work on marital issues. If the individual process is well established, trying to convert it into a marital therapy process as well is rarely successful. The spouse who is brought in usually feels that the therapist's primary loyalty is to the other partner and is rarely able to form an alliance with the therapist. A better solution is to refer the couple to a marital therapist while continuing the original individual process.

Family and marital therapists today must be wary of applying psychodynamic models of gender and role functioning that have a strictly heterosexist bias. In an era in which less than a quarter of Americans live in a household that resembles the standard television sitcom family of the 1950s (Schwartz 2004), therapists must be willing to learn about the unique problems of each family and couple. Assumptions about motherhood, roles of respective parents, and what is projected and introjected need to be reassessed with gay and lesbian families based on the unique narratives that these couples and families present in the consulting room. How does a child, for example, internalize two "moms" instead of one? Competition between two parents of the same gender may be quite different from that experienced by spouses of different genders. All of these factors must be clarified when evaluating and treating families and couples who do not fit into the traditional psychodynamic models.

Dynamic Pharmacotherapy

Several decades ago the phrase "dynamic pharmacotherapy" would have been considered a contradiction in terms. The legacy of mind/body dualism polarized dynamic and pharmacological approaches to psychiatric disorders for many years. Fortunately, recent integrative trends have brought contem-

porary psychiatry to a point at which combined use of medication and psychotherapy is now common practice for both nonpsychotic and psychotic conditions (see Busch and Sandberg 2007; Gabbard 1999; Gabbard and Kay 2001; Thompson and Brodie 1981).

In situations in which formal psychotherapy is not part of the treatment, psychodynamic thinking may be extraordinarily useful in improving compliance with psychotropic regimens. About one-third of patients actually comply adequately with medication as prescribed, one-third more or less comply, and one-third are noncompliant, suggesting that compliance rates generally hover around 50% (Wright 1993). Outpatient compliance with antidepressant medication is only about 40% after 12 weeks (Myers and Branthwaite 1992). Among patients with schizophrenia, 74% of outpatients become noncompliant with their neuroleptic regimens within 2 years of discharge from the hospital (Weiden et al. 1995). Although a switch to depot medication temporarily improves compliance, by 6 months postdischarge there is no difference in compliance rates between patients receiving depot medication and those taking the medication orally.

As discussed in Chapter 8, bipolar patients are also notoriously noncompliant with medication regimens. A further complication in treating noncompliance is that patients tend to seriously underreport the extent to which they are not cooperating with prescribed treatments. A number of studies have used a microprocessor-based method for continuous monitoring of compliance. In this method, a microelectronic circuit records the date and time of each opening and closing of the medication container. One study that used this technology showed that whereas self-reported noncompliance was 7% when assessed by interview, it was 53% when assessed by the microprocessor-based method for continuous monitoring (Dunbar-Jacob 1993).

Adherence to pharmacological treatment has not been systematically studied in the many drug trials reported in psychiatric journals. Only recently have researchers attended to the impact of psychotherapeutic intervention on compliance with medication. A meta-analysis of randomized clinical trials comparing antidepressant treatment alone with antidepressant treatment in combination with a psychological intervention in depression (Pampallona et al. 2004) found that results with combined treatment were better than with drug treatment alone. Moreover, in the longer therapies, the addition of psychotherapy appeared to keep patients in treatment as well. Dropout rates from the studies were improved by the addition of psychotherapy, and one can infer that attention to psychotherapeutic issues in pharmacotherapy, even if formal psychotherapy is not used, may improve compliance. From a psychodynamic perspective, concepts such as transference, countertransference, resistance, and therapeutic alliance are just as important when prescribing medication as when conducting psychotherapy.

Transference

The psychiatrist prescribing medication is no less a transference figure than the psychotherapist. For patients, the decision to comply or not comply with the doctor's recommendations activates unconscious issues of parental expectations. When patients refuse to take medication as prescribed, psychiatrists often react by becoming more authoritarian, insisting that their orders be followed without question. This approach usually backfires because it merely exacerbates the transference disposition to see the doctor as a demanding parental figure. Busch and Sandberg (2007) stress that patients often experience feelings of shame related to their need for psychiatric medication. When the prescribing psychiatrist becomes increasingly authoritarian, the patient may experience himself or herself as being shamed and humiliated by the doctor, making him or her less likely to comply with the doctor's orders.

A far more productive approach is to enlist patients' collaboration in exploring their concerns. A series of questions such as the following may be helpful: "Do you have any concerns about taking medications other than side effects?" "Do you remember problems with taking medication in the past?" "Have you heard anything on television or read anything in the newspaper about this medication?" "Does your family have any special feelings about taking medications?" "What do you think has caused your illness?" "Does this medication have any particular meaning to you?" "What feelings do you have toward the prescribing doctor?"

One patient experienced the prescription of an antidepressant as an empathic failure on the part of the psychiatrist. When the patient's noncompliance was explored with him, he told his doctor, "I was looking for someone to validate my feelings. Instead, you tried to medicate them away." When the psychiatrist encouraged him to elaborate further, the patient was able to connect this feeling with earlier experiences with his father, whom he experienced as inattentive and uncaring about his concerns.

Other patients, especially those who have characterological tendencies to be controlling or dominating, will see medication as a threat to their counterdependent stance. Ciechanowski et al. (2001) applied adult attachment theory in an attempt to better understand noncompliance in diabetics who were on self-management regimens. They found that patients with a dismissing attachment style had significantly higher levels of glycosylated hemoglobin. In addition, among patients with a dismissing attachment style, those who perceived that they have poor communication with their healthcare provider had higher levels compared with those who felt the quality of communication was good. Adults with a dismissing attachment style generally have experienced caregivers or parents as consistently emotionally un-

responsive. They become compulsively self-reliant as a result and try to avoid the kind of collaborative relationship necessary for treatment. Although this study did not involve psychiatric medications, it nevertheless underscores the fact that complying with a medication regimen may mean submitting to the domination of a powerful parental figure. Such patients must be given some control over whether to take medication (Thompson and Brodie 1981). With overly submissive patients, one often encounters the opposite situation. Pills make these patients feel "fed" and taken care of to such an extent that they may decide that they no longer need to take responsibility for any aspect of their illness.

Transference struggles may be particularly intense with whining, "manipulative help-rejecters" (Groves 1978). These patients systematically defeat every treatment intervention, pharmacological or otherwise. They frequently have gone through a lengthy list of psychotropic agents without feeling any benefit. Exploring the transference dynamics may lead to the uncovering of a great deal of resentment and bitterness toward parental figures whom the patient believes did not give enough nurturance. By rejecting help offered to them, these patients may be unconsciously seeking revenge against their parents (Gabbard 1988). When such patients sense that they are making their doctor miserable, they often feel a secret triumph.

A unique aspect of transference in dynamic pharmacotherapy is transference to the medication itself (Gutheil 1982). Placebo responses to medications often have this same transference quality. A manic patient, for example, became markedly subdued after one 300-mg dose of lithium carbonate, a response that could not be explained pharmacologically. Placebo side effects are also common. Another manifestation of transference to medications is the response to changing the drug rituals of chronic patients (Appelbaum and Gutheil 1980). Such patients may decompensate into psychosis with the slightest alteration of their usual medication regimen.

The transference relationship to a medication may be most obvious in situations in which the pill takes the place of the absent doctor. Pills may function as transitional objects for some patients, allowing them to maintain some sense of connectedness with their psychiatrists even when seeing them quite infrequently (Book 1987). Touching or looking at the pill may have a soothing effect on the patient. In training programs, where residents rotate through services on an annual basis, patients may deal with the loss of their doctor by becoming intensely attached to the medication prescribed by the departing doctor (Gutheil 1977).

Transferences of this type are powerful and may lead to another form of noncompliance—refusal to discontinue medications because of the unconscious meaning of the medication to the patient. Transference issues must always be taken into account when prescribing psychotropic agents to

paranoid patients. In more subtle cases, the patient may discontinue a medication for the ostensible reason of unpleasant side effects, when in actuality the patient is afraid of being poisoned. Insistence on compliance will greatly increase the paranoia, whereas empathic exploration of the nature of the fears may help the patient to realize that they are unfounded and to view the therapist as less threatening (Book 1987).

Countertransference

The prescribing of medication is just as likely as any other treatment intervention to be contaminated by countertransference. One common manifestation of countertransference is overprescription. It is not uncommon for a patient to arrive at a hospital or an emergency department with a brown paper bag full of psychoactive agents. One such patient was taking three antipsychotics, two antidepressants, lithium carbonate, and two benzodiazepines. After a few days in the hospital, it was apparent that this patient evoked intense feelings of impotence and anger in treaters. The excessive amounts of medication reflected the countertransference despair of the attending psychiatrist.

Narcissistic injury may also be a factor in countertransference. Some psychotherapists may fail to prescribe a much-needed medication because they believe that doing so would be tantamount to conceding that their psychotherapeutic skills have been ineffective. Others may induce guilt feelings in noncompliant patients so that the patients will feel obligated to comply with the medication regimen out of a wish not to hurt their doctor.

Some psychiatrists become anxious about intense feelings of any kind in the transference. Medication may be viewed as a way to deal with this countertransference anxiety. The discussion of side effects may also be influenced by this anxiety. For example, a psychiatrist may avoid bringing up the sexual side effects of selective serotonin reuptake inhibitors (SSRIs) because of his or her own discomfort with overt sexual discussion. As a result, patients who experience these effects may simply discontinue their medication without informing the physician.

Countertransference anger, which is a common response to noncompliance in patients, may take many forms. Some psychiatrists may collude with the noncompliance to demonstrate how ill their patients will get if they do not follow the "doctor's orders" (Book 1987). Others may bully patients into taking their medications or threaten to discharge them from treatment if they do not comply. Those psychiatrists who have difficulty controlling their anger may refuse to set limits on patients who demand increasing amounts of medication. In these cases the psychiatrist hopes that gratifying the demands of the patient will keep aggression and hostility out of the therapeutic relationship. Unfortunately, the patient's demandingness and anger usually escalate.

Resistance

Resistance to treatment is as powerful a force in pharmacotherapy as it is in psychotherapy. Illness may be preferable to health for numerous reasons. It is well known, for example, that patients with bipolar affective disorder may enjoy their manic episodes so much that they will stop taking their lithium. In one study of schizophrenic patients (Van Putten et al. 1976), a similar cause of resistance was uncovered. In this investigation, side effects and secondary gain had little to do with noncompliance. An ego-syntonic grandiose psychosis was the most powerful discriminating factor that distinguished schizophrenic patients who did not comply from those who did. Clearly, the noncompliant patients preferred their experience of psychotic grandiosity. Goldberg and Ernst (2012) point out that the psychoanalytic construct of *negative therapeutic reactions* may apply to pharmacotherapy as well. Certain patients, often because of rage at early caregivers, may take conscious or unconscious sadistic pleasure at thwarting the prescriber's efforts. They dismiss one agent after another as utterly without benefit.

Denial of illness is also a prominent cause of resistance to pharmacotherapy. For some patients, any psychotropic agent carries with it the stigma of mental illness. When an acute psychotic episode goes into remission, a patient may stop the antipsychotic medication responsible for the remission because maintenance treatment connotes a chronic mental illness. Nonpsychotic patients who are quite willing to submit to psychotherapeutic treatment will balk at the suggestion of medication because they are convinced it means that they are more seriously disturbed than they like to think. Likewise, patients who have had a relative in psychopharmacological treatment may unconsciously identify with that relative when offered the same medication (Book 1987). This identification may serve as a resistance to accepting treatment, particularly if the relative had an especially unfavorable outcome, such as suicide.

Therapeutic Alliance

The foregoing discussion about noncompliance should make it clear that the therapeutic alliance plays a crucial role in dynamic pharmacotherapy. Numerous authors have stressed that attending to the therapeutic alliance is part of the prescribing process (Docherty and Fiester 1985; Elkin et al. 1988; Gutheil 1982; Howard et al. 1970). Although much contemporary psychopharmacological research does not quantify the doctor–patient relationship, many investigators have noted its influence on compliance. One study (Howard et al. 1970) discovered that subtle aspects of the therapist's behavior, including vocal enthusiasm, body language, and use of the patient's name,

differentiated psychiatrists with low dropout rates from those with high attrition rates. This study also indicated that attention to the therapeutic alliance in the first session prevented noncompliance with drug treatment. A more recent study (Ratanawongsa et al. 2013) from an internal medicine setting looked at the link between good communication and medication refill adherence in diabetics. The investigators found that about 30% of the patients had not taken their medication as prescribed. However, the noncompliance rate was only 4%–6% for patients who described their doctor as having established a trusting relationship with the patient. In fact, the doctors who were better communicators had better rates of patient medication adherence, even if the communication was not specifically focused on the medication itself. Even in nonpsychiatric medical settings, the doctor–patient relationship may be essential to the establishment of good adherence to the treatment plan.

Research on depressed patients has indicated that the therapeutic alliance may be a key factor regardless of the type of treatment. Even if a patient is being treated primarily with antidepressant medication, the psychodynamic construct of the therapeutic alliance is just as important as it is when a patient is receiving only psychotherapy. A team of researchers (Krupnick et al. 1996) examined a sample of 225 depressed patients in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Clinical raters scored videotaped transcripts of treatment sessions in all four cells: 16 weeks of cognitive therapy, 16 weeks of interpersonal therapy, 16 weeks of imipramine plus clinical management, and 16 weeks of placebo plus clinical management. When outcomes were assessed for these patients, the therapeutic alliance was found to have a significant effect on clinical outcome for all four cells. In fact, patient contribution to the therapeutic alliance accounted for 21% of the outcome variance on standardized outcome measures, with more of the variance in outcome attributed to the total alliance than to the treatment method itself! Among the four cells, none showed significant group differences in terms of the relationship between therapeutic alliance and clinical outcome. This was the first empirical study to show that the therapeutic alliance had the same effect on outcome regardless of whether the treatment was psychotherapy or pharmacotherapy.

Studies of the dropout rate in both psychotherapeutic and psychopharmacological treatment settings have emphasized that patient expectations can influence attrition (Freedman et al. 1958; Overall and Aronson 1963). Different patients come to a psychiatrist with different expectations of the kind of treatments available. At some point in the first interview, psychiatrists should explore their patients' expectations so that the treatment prescribed is in some way consistent with them. If the treatment of choice is counter to a patient's preconceived notions, an educational effort may be necessary to convince the patient of its usefulness.

Research on the placebo effect provides intriguing perspectives on the role of patient expectation. In one study (Wager et al. 2004), subjects were given an inactive cream that they were told was being used for analgesia. They were then given a painful heat stimulation or shock on the wrist. Those who showed increased activity in the prefrontal cortex prior to the stimulus also showed the biggest reduction of activity in pain-sensitive brain regions and reported subjective pain reduction. The investigators concluded that the results implied that anticipating pain relief is intimately tied with actual pain reduction. Cognitive control related to the prefrontal activity may help patients adopt a mindset associated with pain relief. Similarly, careful education of patients about the agent being prescribed and attention to the doctor–patient relationship may provide a context of positive expectation that might facilitate a reduction in the cognitive components of depression.

The counterpart of the placebo effect, which is brought on by the patient's positive expectations, is the nocebo effect, which is brought on by negative expectations. Well-designed research has demonstrated that negative verbal information from the doctor can convert nonpainful stimulation into a level of painful experience that is remarkably similar to painful stimuli (Colloca and Finniss 2012). Studies involving nocebo effects underscore the significance of how potential negative effects or side effects are conveyed to the patient within the doctor-patient relationship. The way in which potential negative effects are presented to the patient may contribute to actual clinical outcomes. Although one has an ethical obligation linked to informed consent to present possible adverse effects of the medication, the psychiatrist must incorporate a positive overall outlook for the results and provide percentages in a way that minimizes attention on the negative aspects of the medication (Colloca and Finniss 2012).

In Chapter 4, the concept of collaboration was emphasized in the discussion of the therapeutic alliance in psychotherapy. An analogous concept of "participant prescribing" (Gutheil 1982) is relevant for pharmacotherapy. The unconscious tendency of some psychiatrists to switch to a more authoritarian mode when prescribing medications is liable to backfire in the form of noncompliance. The variable of patient education positively influences the development of a therapeutic alliance in pharmacotherapy.

Special types of compliance problems are often encountered when medication is added to an ongoing psychotherapy process, as in the following example:

> Ms. D, a 39-year-old married professional woman, came to psychiatric treatment because of feelings of depression, low energy, lack of satisfaction in her job, difficulty sleeping, and decreased sex drive. She seemed extremely grateful for the opportunity to have someone listen to her. After a few weeks and

several sessions of psychotherapy, Ms. D began to feel a great deal of trust in her therapist. She poured out her heart in a poignant and moving manner during the sessions. With a great many tears, she told of the extraordinary difficulties in her life and the problems she encountered at home and at work.

After about 6 weeks of these sessions, her therapist told her that her symptoms were of sufficient severity that he was going to prescribe an antidepressant for her. The therapist wrote out the prescription, explained the side effects she might encounter, and sent her on her way with instructions to begin taking the medication immediately.

The following week Ms. D came for her appointment and began talking once again about her problems but made no mention of the medication. When her therapist asked her how she was doing with the agent he had prescribed, she said that she had not had time to go to the pharmacy to fill the prescription but that she would do so in the next few days. The therapist again emphasized the importance of starting on the medication as soon as possible. Ms. D minimized her failure to fill the prescription and reassured her therapist that she would do so before the next appointment.

A week passed and Ms. D returned for her therapy session. Once again she reported that she had failed to go to the pharmacy. Knowing that this lack of compliance was reflecting some dynamic that was not readily apparent, her therapist explored with her what reasons she might have for not wanting to take the medication. With some reluctance Ms. D admitted that she was very much afraid that she was receiving medication because her therapist did not want to hear all the complaints she brought to each session. Ms. D experienced the prescription as though she was being told to "shut up." Her therapist asked her if she had had any similar experiences in her life. She went on to say that her father was not a verbal person and that he had chastised her throughout her childhood and adolescence for complaining all the time. Ms. D also noted that her husband was much the same way and had urged her to go to a psychiatrist so he wouldn't have to listen to her complaints. She feared that her therapist would no longer see her for psychotherapy if she responded well to the medication.

The therapist told her that medication and psychotherapy were not mutually exclusive and that he would continue to work psychotherapeutically with her while she was taking medication. Ms. D seemed relieved to have that reassurance, and she complied with the prescription on a regular basis after that session.

Today, the question is no longer whether the combination of psychotherapy and medication is beneficial but rather how the combination is beneficial (Gabbard and Bartlett 1998; Gabbard and Kay 2001). There are unlimited variations in how the two may interact in any particular treatment. Likewise, there are many variations in how patients respond when medication is added to their psychotherapy. Some patients will feel that the treatment is being turned over to medication and that the therapist is giving up on them (Roose and Stern 1995). Other patients will feel that the medication helps them get more out of the therapy.

Clinicians who combine the approaches must be aware of the "bimodal relatedness" inherent in the dual role (Docherty et al. 1977). The patient must be viewed simultaneously as a disturbed person and as a diseased central nervous system. The former view requires an empathic, subjective approach, whereas the latter demands an objective, medical model approach. The clinician must be able to shift between these two modes gracefully while remaining attuned to the impact of the shift on the patient.

Psychiatrists combining psychotherapy and medication may also be perplexed regarding the most tactful way to raise medication issues during a psychotherapy session (Gabbard and Kay 2001). Unfortunately, the technical strategy cannot be reduced to "cookbook-like" guidelines. With some patients, the discussion of medication will serve as a resistance to working on psychotherapeutic issues. With others, the patient will emphasize psychodynamic themes designed to capture the therapist's interest while completely avoiding issues involving medication, such as sexual side effects, that may be embarrassing to discuss. With some patients at some points in the therapy process, bringing up the medication at the beginning may be optimal. With others, reserving 5 minutes at the end to discuss medication may serve the therapy better. In still others, medication issues may be interwoven within the very fabric of the psychotherapy themes and will be discussed intermittently throughout the entire session.

The fundamental compatibility of biology and psychodynamics was emphasized in Chapter 1. One instance of this marriage is the increasing practice of combining pharmacotherapy and psychotherapy. Because conceptual bridges are still being built between the two approaches, much of the practice remains empirical at this point. As in all psychiatry, the guiding principle must be to help the patient rather than to remain true to one's theoretical biases.

References

Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340–346, 1980

Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry 158:36–42, 2001

Bateson G, Jackson DD, Haley J, et al: Toward a theory of schizophrenia. Behav Sci 1: 251–264, 1956

Berkowitz DA: An overview of the psychodynamics of couples: bridging concepts, in Marriage and Divorce: A Contemporary Perspective. Edited by Nadelson CC, Polonsky DC. New York, Guilford, 1984, pp 117–126

Bion WR: Experiences in Groups and Other Papers. New York, Basic Books, 1961

Book HE: Some psychodynamics of non-compliance. Can J Psychiatry 32:115–117, 1987

Bowen M: Family Therapy in Clinical Practice. New York, Jason Aronson, 1978

Busch FN, Sandberg LS: Psychotherapy and Medication: The Challenge of Integration. New York, Analytic Press, 2007

Chapman CL, Bulingame GM, Gleave R, et al: Clinical prediction in group psychotherapy. Psychother Res 22: 673–681, 2012

Ciechanowski PS, Katon W, Russo J, et al: The patient–provider relationship: attachment theory and adherence to treatment in diabetes. Am J Psychiatry 158:29–35, 2001

Colloca L, Finniss D: Nocebo effects, patient-clinician communication, and therapeutic outcomes. JAMA 307:567–568, 2012

Dicks HV: Object relations theory and marital studies. Br J Med Psychol 36:125–129, 1963

Docherty JP, Fiester SJ: The therapeutic alliance and compliance with psychopharmacology, in Psychiatry Update: American Psychiatric Association Annual Review, Vol 4. Edited by Hales RE, Frances AJ. Washington, DC, American Psychiatric Press, 1985, pp 607–632

Docherty JP, Marder SR, Van Kammen DP, et al: Psychotherapy and pharmacotherapy: conceptual issues. Am J Psychiatry 134:529–533, 1977

Dunbar-Jacob J: Contributions to patient adherence: is it time to share the blame? Health Psychol 12:91–92, 1993

Elkin I, Pilkonis PA, Docherty JP, et al: Conceptual and methodological issues in comparative studies of psychotherapy and pharmacotherapy, I: active ingredients and mechanisms of change. Am J Psychiatry 145:909–917, 1988

Ezriel H: A psycho-analytic approach to group treatment. Br J Med Psychol 23:59–74, 1950

Freedman N, Engelhardt DM, Hankoff LD, et al: Drop-out from outpatient psychiatric treatment. Arch Neurol Psychiatry 80:657–666, 1958

Gabbard GO: A contemporary perspective on psychoanalytically informed hospital treatment. Hosp Community Psychiatry 39:1291–1295, 1988

Gabbard GO: Combined pharmacotherapy and psychotherapy, in Comprehensive Textbook of Psychiatry VII, Vol 2. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1999, pp 2225–2234

Gabbard GO, Bartlett AB: Selective serotonin reuptake inhibitors in the context of an ongoing analysis. Psychoanalytic Inquiry 18:657–672, 1998

Gabbard GO, Kay J: The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? Am J Psychiatry 158:1956–1963, 2001

Ganzarain RC: Psychotic-like anxieties and primitive defenses in group analytic psychotherapy. Issues in Ego Psychology 3:42–48, 1980

Ganzarain RC: Working through in analytic group psychotherapy. Int J Group Psychother 33:281–296, 1983

Gibbard GR, Hartman JJ: The significance of utopian fantasies in small groups. Int J Group Psychother 23:125–147, 1973

Gillaspy JA Jr, Wright AR, Campbell C, et al: Group alliance and cohesion as predictors of drug and alcohol abuse treatment outcomes. Psychotherapy Research 12: 213–229, 2002

Glick ID, Berman EM, Clarkin JF, et al: Marital and Family Therapy, 4th Edition. Washington, DC, American Psychiatric Press, 2000

Goldberg JF, Ernst CL: Managing the Side Effects of Psychotropic Medication. Washington, DC, American Psychiatric Publishing, 2012

Groves J: Taking care of the hateful patient. N Engl J Med 298:883–887, 1978

Gutheil TG: Psychodynamics in drug prescribing. Drug Ther 2:35–40, 1977

Gutheil TG: The psychology of psychopharmacology. Bull Menninger Clin 46:321–330, 1982

Holmes SE, Kivlighan Jr DM: Comparison of therapeutic factors in group and individual treatment processes. J Couns Psychol 47:478–484, 2000

Horwitz L: A group-centered approach to group psychotherapy. Int J Group Psychother 27:423–439, 1977

Horwitz L: Projective identification in dyads and groups. Int J Group Psychother 33: 259–279, 1983

Howard K, Rickels K, Mock JE, et al: Therapeutic style and attrition rate from psychiatric drug treatment. J Nerv Ment Dis 150:102–110, 1970

Jones SA, Gabbard GO: Marital therapy of physician couples, in Medical Marriages. Edited by Gabbard GO, Menninger RW. Washington, DC, American Psychiatric Press, 1988, pp 137–151

Kohut H: How Does Analysis Cure? Edited by Goldberg A. Chicago, IL, University of Chicago Press, 1984

Krupnick JL, Sotsky SM, Simmens S, et al: The role of therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin Psychol 64:532–539, 1996

Lambert MJ, Bergin AE: The effectiveness of psychotherapy, in Handbook of Psychotherapy and Behavior Change, 4th Edition. Edited by Bergin AE, Garfield SL. New York, Wiley, 1994, pp 143–189

Lo Coco G, Gullo S, Kivlighan DM: Examining patients' and other group members' agreement about their alliance to the group as a whole and changes in patient symptoms using response surface analysis. J Couns Psychol 59:197–207, 2012

MacKenzie KR: The time-limited psychotherapies: an overview, in American Psychiatric Press Review of Psychiatry, Vol 15. Edited by Dickstein LJ, Riba MB, Oldham JM. Washington, DC, American Psychiatric Press, 1996, pp 11–21

MacKenzie KR: Time-Managed Group Psychotherapy: Effective Clinical Applications. Washington, DC, American Psychiatric Press, 1997

Minuchin S: Families and Family Therapy. Cambridge, MA, Harvard University Press, 1974

Myers ED, Branthwaite A: Out-patient compliance with antidepressant medication. Br J Psychiatry 160:83–86, 1992

Ogden TH: Projective Identification and Psychotherapeutic Technique. New York, Jason Aronson, 1982

Overall B, Aronson H: Expectations of psychotherapy in patients of lower socioeconomic class. Am J Orthopsychiatry 33:421–430, 1963

Pampallona S, Bollini P, Tibaldi G, et al: Combined pharmacotherapy and psychological treatment for depression: a systematic review. Arch Gen Psychiatry 61:714–719, 2004

Piper WE, McCallum M, Azim HFA: Adaptation to Loss Through Short-Term Group Psychotherapy. New York, Guilford, 1992

Polonsky DC, Nadelson CC: Psychodynamic couples therapy, in Textbook of Family and Couples Therapy: Clinical Applications. Edited by Sholevar GP, Schwoeri LD. Washington, DC, American Psychiatric Publishing, 2003, pp 439–459

Porter K: Combined individual and group psychotherapy, in Comprehensive Group Psychotherapy, 3rd Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1993, pp 314–324

Ratanawongsa N, Karter AJ, Parker MM, et al: Communication and medication refill adherence: the diabetes study of Northern California. JAMA Intern Med 173:210–218, 2013

Redl F: Psychoanalysis and group therapy: a developmental point of view. Am J Orthopsychiatry 33:135–147, 1963

Ringstrom PA: An intersubjective approach to conjoint therapy, in Progress in Self Psychology, Vol 10. Edited by Goldberg A. Hillsdale, NJ, Analytic Press, 1994, pp 159–182

Ringstrom PA: Competing selfobject functions: the bane of the conjoint therapist. Bull Menninger Clin 62:314–325, 1998

Ringstrom P: A Relational Psychoanalytic Approach to Couples Therapy. New York, Routledge, 2014

Rioch MJ: The work of Wilfred Bion on groups. Psychiatry 33:56–66, 1970

Roose SP, Stern RH: Medication use in training cases: a survey. J Am Psychoanal Assoc 43:163–170, 1995

Rutan JS, Stone WN: Psychodynamic Group Psychotherapy: Third Edition. New York, Guilford, 2001

Sadock BJ: Preparation, selection of patients, and organization of the group, in Comprehensive Group Psychotherapy, 2nd Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams and Wilkins, 1983, pp 23–32

Scharff DE, Scharff JS: Object Relations Family Therapy. Northvale, NJ, Jason Aronson, 1987

Scharff DE, Scharff JS: Object Relations Couple Therapy. Northvale, NJ, Jason Aronson, 1991

Scheidlinger S: On the concept of the "mother-group." Int J Group Psychother 24:417–428, 1974

Schwartz AE: Ozzie and Harriet are dead: new family narratives in a postmodern world, in Uncoupling Convention: Psychoanalytic Approaches to Same-Sex Couples and Families. Edited by D'Ercole A, Drescher J. Hillsdale, NJ, Analytic Press, 2004, pp 13–29

Selvini Palazzoli M, Boscolo L, Cecchin G, et al: Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction. New York, Jason Aronson, 1978

Shaddock D: From Impasse to Intimacy: How Understanding Unconscious Needs Can Transform Relationships. Northvale, NJ, Jason Aronson, 1998

Shapiro ER, Zinner J, Shapiro RL, et al: The influence of family experience on borderline personality development. International Review of Psychoanalysis 2:399–411, 1975

Sholevar GP, Schwoeri LD: Psychodynamic family therapy, in Textbook of Family and Couples Therapy: Clinical Applications. Edited by Sholevar GP, Schwoeri LD. Washington, DC, American Psychiatric Publishing, 2003, pp 77–102

Slipp S: Object Relations: A Dynamic Bridge Between Individual and Family Treatment. New York, Jason Aronson, 1984

Slipp S: The Technique and Practice of Object Relations Family Therapy. Northvale, NJ, Jason Aronson, 1988

Sperry L, Brill PL, Howard KI, et al: Treatment Outcomes in Psychotherapy and Psychiatric Interventions. New York, Brunner/Mazel, 1996

Stewart RH, Peters TC, Marsh S, et al: An object-relations approach to psychotherapy with marital couples, families, and children. Fam Process 14:161–178, 1975

Thompson EM, Brodie HKH: The psychodynamics of drug therapy. Curr Psychiatr Ther 20:239–251, 1981

Van Putten T, Crumpton E, Yale C: Drug refusal in schizophrenia and the wish to be crazy. Arch Gen Psychiatry 33:1443–1446, 1976

Wager TD, Rilling JK, Smith EE, et al: Placebo-induced changes in fMRI in the anticipation and experience of pain. Science 303:1162–1167, 2004

Weiden P, Rapkin B, Zymunt A, et al: Postdischarge medication compliance of inpatients converted from an oral to a depot neuroleptic regimen. Psychiatr Serv 46: 1049–1054, 1995

Whitaker DS, Lieberman MA: Psychotherapy Through the Group Process. New York, Atherton Press, 1964

Wilberg T, Karterud S, Pedersen G, et al: Outpatient group psychotherapy following day treatment for patients with personality disorders. J Pers Disord 17:510–521, 2003

Wright EC: Non-compliance—or how many aunts has Matilda? Lancet 342:909–913, 1993

Yalom ID: The Theory and Practice of Group Psychotherapy, 3rd Edition. New York, Basic Books, 1985

Zeitner R: Self Within Marriage: The Foundation Basis for Lasting Relationships. New York, Routledge, 2012

Zinner J: The implications of projective identification for marital interaction, in Contemporary Marriage: Structure, Dynamics, and Therapy. Edited by Grunebaum H, Christ J. Boston, MA, Little, Brown, 1976, pp 293–308

Zinner J, Shapiro R: Projective identification as a mode of perception and behavior in families of adolescents. Int J Psychoanal 53:523–530, 1972

Zinner J, Shapiro R: The family as a single psychic entity: implications for acting out in adolescence. International Review of Psychoanalysis 1:179–186, 1974

CHAPTER 6

TREATMENTS IN DYNAMIC PSYCHIATRY

Multiple-Treater Settings

Because psychodynamic principles evolved largely from the practice of psychoanalysis, these precepts are sometimes narrowly construed to be relevant only to outpatient treatment. One psychiatric resident asked his supervisor for help in understanding a hospitalized patient only to be told, "Dynamics apply only to outpatients, not inpatients." Nothing could be further from the truth, of course. However, the supervisor's comment reflects an unfortunate trend in modern hospital psychiatry to use the psychiatric unit as a mere holding tank where patients wait for their medication to take effect. The treatment of many patients is greatly enhanced by approaching hospital treatment with a dynamic perspective.

Psychiatric hospitals have witnessed a dramatic decline in length of stay related to aggressive utilization review by insurance companies and managed care firms (Gabbard 1992a, 1994). As a result, much of the valuable information gleaned from extended hospital treatment of seriously disturbed patients was adapted for use in other settings, such as partial or day hospitals. Even in hospital settings, however, psychodynamically informed strategies have continued to be of considerable usefulness as they have been modified to a more circumscribed focus in the acute care setting (Gabbard 1997). Whether the treatment is carried out during a brief hospital stay or a more extended treatment in a partial hospital service, there are certain advantages and challenges

associated with a multiple-treater setting. In this chapter I examine how psychodynamic thinking can be usefully applied to such settings. The models discussed should be considered to be equally applicable in hospital treatment, day hospitals, and intensive outpatient settings involving multiple treaters.

A Historical Review

The practitioner can draw on a long tradition of the application of psychoanalytic principles to hospital treatment. The history of the notion of the psychoanalytic hospital began with Simmel's (1929) work at Schloss Tegel in Berlin, where he noted that certain patients could not be analyzed outside a hospital because of various symptomatic behaviors, such as alcoholism or phobias. He had the idea that a hospital could extend the patient's hour on the couch by training hospital staff members to conduct quasi-analytic treatment in the milieu as issues of transference and resistance arose.

In his creative and brilliant *Guide to the Order Sheet,* Will Menninger (1939/1982) deemphasized the model of individual psychoanalysis and attempted to apply the principles of psychoanalysis directly within the hospital by manipulation of the milieu. Working from the assumption that all symptoms and disturbed behaviors derive from disturbances in the proper fusion and expression of the two major instinctual drives—libido and aggression—he evolved a system of milieu treatment based largely on sublimation and not requiring insight. Rather than frustrating or interpreting unconscious wishes and conflicts, this approach focused on rechanneling energies into less harmful paths. For example, Menninger encouraged the direct expression of hostilities toward substitute objects; prescriptions for a patient might range from demolishing a building to punching a punching bag. Unfortunately, this second model could not take into account those patients with ego weaknesses involving impulse control problems who required a treatment designed to help them gain more control over drive expression rather than to redirect it. Moreover, this conceptualization was limited by confining itself to the dual instinct theory of the times, which tended to neglect the object relations context in which disturbed drives occur and did not allow for systematic examination of transference and countertransference in the milieu.

The third model grew out of an awareness that patients were re-creating with various staff members in the hospital setting their conflicts with their own family members (Hilles 1968). Interpretation of maladaptive behavior patterns in terms of their roots in the past was common within this model, which relied less and less on providing substitute outlets for unconscious needs. The milieu was not seen as a therapeutic community in which real,

constructive experiences with peers are stressed but rather as a screen upon which archaic patterns are projected and then examined.

A number of authors (Gabbard 1986, 1988, 1989c, 1992a; Harty 1979; Stamm 1985b; Wesselius 1968; Zee 1977) pinpointed the understanding of countertransference as an integral part of this model. Countertransference influences occur regularly, rather than occasionally, and the systematic examination of the countertransference should be part of the routine work of the treatment team. A recurring theme throughout the various formulations of psychoanalytically informed hospital treatment is that patients re-create in the milieu environment their own internal object relations. This point of view is reflected in Kernberg's (1973) integrative attempt to synthesize psychoanalytic object relations theory, systems theory, and the use of group process in an overall approach to hospital treatment. One basic tenet of his approach is that there exists in all of us a potential for both higher-level object relationships and more primitive levels, which may lead to regression in group situations. He theorized that whereas the higher level of object relationship is activated in individual therapeutic relationships, the more primitive version is much more likely to be activated in group treatment modalities. A combination of individual and group treatment in hospitalization provides for intervention at both levels.

Dynamic Principles in Contemporary Hospital Treatment

A dynamic approach provides for a diagnostic understanding that pays careful attention to patients' ego weaknesses and strengths, their intrapsychic object relations as manifested in family and social relationships, their capacity for psychological work, and the childhood origins of their current problems. A psychodynamic assessment may lead a clinician to conclude that interpretive interventions and uncovering of unconscious material are ill advised. With patients who have significant ego weakness and/or organically based cognitive impairment, ego-supportive approaches and those geared to building self-esteem may be recommended.

Psychoanalytic theories of development are useful in designing inpatient treatment plans. A psychoanalytically informed hospital team realizes that the majority of its patients are developmentally arrested. Knowledge of psychoanalytic theory allows the team to respond at an appropriate developmental level, accepting the notion that the patient is a child in an adult's body. This perspective helps the staff avoid the perils of depersonification (Rinsley 1982), whereby the patient is expected to behave as a mature and polite adult despite severe psychopathology. Such depersonification has of-

ten been the life story of the severely disturbed patient in terms of interactions with family members.

Psychoanalytic theory provides models of interventions geared to the patient's phase-appropriate developmental needs, such as empathic mirroring (Kohut 1971) and the provision of a holding environment (Stamm 1985a; Winnicott 1965). Within this context, the limits associated with hospital structure are viewed not as punishments for immature and irritating behavior but as external substitutes for missing intrapsychic structures. In a similar vein, staff members must perform auxiliary ego functions, such as reality testing, impulse control, anticipation of consequences (judgment), and sharpening of self–object differentiation. From an attachment theory perspective, milieu staff provide a secure base for patients. Intense affects are contained for patients until they can be modulated by the patients themselves. Staff members foster attachment by listening to patients' personal narratives and attempting to understand their perspectives (Adshead 1998).

Patients who enter an inpatient unit or a day hospital tend to repeat their family situations in the milieu. To be more precise, they externalize their internal object relations. The recapitulation of the patient's internal object relations in the interpersonal field of the milieu can best be understood by an examination of the defense mechanisms of splitting and projective identification. Although these mechanisms are operative to some degree in neurotic patients, they are most prevalent in patients with borderline and psychotic levels of ego organization, features that also happen to characterize the group of patients most commonly found in inpatient settings. Moreover, these mechanisms are undoubtedly activated in part by the group dynamics inherent in inpatient or day hospital teamwork. Splitting and projective identification work in tandem to disavow and externalize self or object representations often associated with specific affective states. This projective disavowal is also a means of coercing persons in the environment to participate in an externalized version of an internal object relationship.

Projective identification operates unconsciously, automatically, and with compelling force. Clinicians feel "bullied" or coerced into complying with the role that has been projectively attributed to them. A basic axiom of psychodynamically informed treatment acknowledges that staff members are more similar to patients than different from them. The feelings, fantasies, identifications, and introjects within patients have their counterparts in treaters. Because those counterparts may be more strongly repressed in staff, when activated by a patient they often are experienced as alien forces sweeping over the treater. Symington (1990) characterized this projective identification process as a bully/victim paradigm in which one is deprived of the freedom to think one's own thoughts. Indeed, clinicians who are the targets of the projected material often feel that they are in a form of bondage to the

patient in that they cannot think, feel, or function in their usual therapeutic role.

Defining projective identification in this manner suggests that much of the intense countertransference experienced by staff members can be understood as stemming from unconscious identifications with projected aspects of the patient's internal world. However, it would be naive and oversimplistic to assume that all the emotional reactions arising in treaters can be attributed to the patient's behavior. Clinicians will also manifest emotional reactions in keeping with the classical, or narrow, form of countertransference, in which treaters react to patients as though they are people from the treaters' past. One of the advantages of working in the context of a treatment team is that staff members can help one another distinguish characteristic countertransference patterns based on the staff members' own psychological issues from those that are coerced identifications with aspects of the patient's projected internal world. It would be ideal if each staff member could make such distinctions individually, but such expectations are not realistic in multiple-treater settings.

To describe the mechanisms of splitting and projective identification provides only a partial explanation of the tendency for patients to externalize their internal object relations within the milieu relationships. To point out that this repetition occurs unconsciously, automatically, and with a coercive force does not adequately account for the unconscious motivational forces behind the repetition. At least four different forces can be identified that contribute to the repetition of internal object relations (Gabbard 1992b; Pine 1990).

Active Mastery of Passively Experienced Trauma

In re-creating internalized patterns of relating in the inpatient or day hospital setting, patients may be attempting to actively master passively experienced trauma. By reactivating problematic relationships, patients may gain a feeling of mastery and control over past traumatic relationships because this time they are in charge.

Maintenance of Attachments

Object relations units are also reestablished with treaters because the new relationship serves as a way of maintaining attachments to key persons from childhood, most notably parents. Even if childhood relationships with parents are abusive and conflictual, the child will nevertheless view them as a source of pleasure (Pine 1990). A sadomasochistic relationship is better than no relationship at all (Gabbard 1989b). Moreover, even "bad" or tormenting relationships may be soothing in the sense that they are predictable and re-

liable and provide the patient with a sense of continuity and meaning (Gabbard 1998). The alternative is a profound sense of abandonment and the associated separation anxiety.

A Cry for Help

To view projective identification only as a mechanism of defense is reductionistic (see Chapter 2). As the targeted person of the projected material powerfully experiences, it is also a form of communication (Casement 1990; Gabbard 1989a; Ogden 1982). Primitive anxieties operate in a way that make patients feel extraordinary pressure to get rid of unmanageable affects, including the self and object representations associated with those affects. Some relief is provided when a treater is forced to experience projected material that is overwhelming to a patient. The patient may be unconsciously communicating to the clinician, "I cannot articulate my internal experience, but by creating similar feelings in you, maybe you can empathize with my inner struggles and somehow help me." Hence, although projective identification may be designed to rid oneself of overwhelming feelings and externalize them in an interpersonal context, it is also a means of seeking help with those feelings through a rudimentary form of empathy (Casement 1990).

A Wish for Transformation

Abusive internal object relations may also be externalized in the hope that they can be transformed. Sandler and Sandler (1978) observed that patients internalize a wished-for interaction, a fantasy of themselves relating to a parent who is responding to them in a manner that is wish fulfilling. In this sense, one can infer that old relationships are repeated with the unconscious hope that this time they will be different (i.e., both the object and the self will be transformed into the fantasy relationship for which the patient longs).

A day hospital or an inpatient unit can provide a new and different form of interpersonal relatedness that facilitates the internalization of less pathological object relatedness. Initial responses to a patient may be similar to those of others in the patient's environment, but as staff members familiarize themselves with the internal object world of the patient, they strive to contain the projections rather than identify with them. In so doing, a vicious circle is broken. The patient is confronted with a group of persons who respond differently from everyone else. These people attempt to understand the interpersonal process instead of automatically joining the "dance."

Weiss et al. (1986), who studied audiotaped transcripts of analyses, concluded that one curative factor of analysis is the analyst's failure to respond

as the analysand expects. According to these investigators, a patient develops pathological beliefs based on early interactions with parental figures and then seeks unconsciously to disconfirm these beliefs in analysis so that development can proceed. Their research is very much applicable to multiple-treater settings, where patients continually but unconsciously test staff members to see whether they will be different from previous figures in the prehospital environment. This situation requires a caveat, however. Staff members who simply "act nice" to the patient may prevent the patient from reexperiencing and working through old patterns of relatedness. Hence, there is always an optimal balance between serving as a new object and serving as an old object in any treatment setting (Gabbard and Wilkinson 1994). Over time, the "old object" patterns of relatedness are gradually replaced by new modes of relatedness based on new experiences with treatment staff and a newfound understanding on the part of the patient of his or her unconscious need to re-create past relationships.

Within this formulation of internal object relations, the therapeutic task is to diagnose carefully the patient's self and object representations and to maintain a diligent vigilance regarding the nature of the projected internal selves and objects at any given time. Implied in this task is the assumption that treaters have sufficient familiarity with their own internal self and object configurations so that they can sort out the two varieties of countertransference.

In this transference-countertransference–based model of treatment, the treatment staff must maintain an openness to the powerful feelings engendered by these patients. Examining the countertransference must be an integral part of the treatment process. The staff should allow themselves to serve freely as containers for the patient's self and object projections and for the affects connected with the object relations. On an individual basis, this approach means avoiding the "dedicated physician" stance described by Searles (1967/1979), in which the treater attempts to be loving at all times as a defense against vulnerability to directing sadism and hatred toward the patient. If the treater is overcontrolled or overdefended against emotional reactions to the patient, the diagnostic process of delineating these internal object relations will be flawed. Even more importantly, the treatment process will be a charade; the patient will be unable to view the treater as a genuine person involved in a fleshed-out whole-object relationship.

Despite increasing pressure in recent years to use staff meetings for documentation of behaviorally oriented treatment plans, the staff members' emotional reactions to patients must be discussed openly and with understanding. If staff meetings become merely task-oriented administrative sessions without time for processing transference–countertransference paradigms, subsequent staff dysfunction will cause the clinical work to suffer.

Furthermore, the team will no longer be involved in dynamically informed treatment but simply in "case management."

The attitude of the unit or team leader is crucial in setting the tone for countertransference-based discussions. The leader must model for the other staff members by openly examining his or her own feelings and relating them to the internal object relations of the patient. The leader must also value and accept the expressions of feelings on the part of other staff members and avoid interpreting them as a manifestation of unresolved and unanalyzed conflicts within the individual staff member. When a staff member shares a disturbing feeling involved in treating a patient, the leader needs to ask questions such as "Why does the patient need to evoke that reaction in you?" "What is he repeating?" "What figure in the patient's past are you identifying with?" "How can we use the feelings the patient evokes in you to understand how his spouse or friends must react to him?" The leader of the treatment team should also become familiar with each staff member's usual style of relating to patients. This awareness must include a knowledge of typical countertransference reactions to certain kinds of patients as well as functioning that is more adaptive and conflict-free. This familiarity will help the team leader pinpoint deviations from the characteristic patterns of relationships with patients. Obviously, in some instances the leader of a treatment team may need to approach individual staff members privately about their need for personal treatment or a change in career.

Members of the treatment team should be given the expectation that they will experience powerful feelings toward the patient that can be used as a diagnostic and therapeutic tool. A distinction can be made between having feelings and acting on them. Obviously, staff should be advised to note and discuss with other staff but to not act on feelings of a destructive or erotic nature. They should be encouraged to process their feelings in staff meetings and to use those feelings to diagnose and understand the internal object relations of the patient. As the treatment progresses, the staff members will be armed with a greater understanding of the patient's internal object relations so that they are much less prone to countertransference identification and can instead clarify patients' distortions and the nature of their internal object worlds. Hence, if the staff members are given permission to experience powerful countertransference feelings and to discuss them early in the treatment of a given patient, they will be able to approach the patient more objectively as the treatment progresses.

If treaters are inclined to deny their countertransference hatred, anger, and contempt out of guilt, they will nevertheless communicate their intense negative feelings nonverbally (Poggi and Ganzarain 1983). Patients are extraordinarily adept at detecting these communications and may, as a result, become increasingly paranoid. As staff members acknowledge their own am-

bivalence and deal with it more openly, patients will be able to acknowledge their ambivalence and to be less afraid of their hatred. As long as staff members deny their hatred, they only confirm the patient's fear that such feelings are unspeakable and must be avoided at all cost.

The model of staff–patient interaction suggested here is directly analogous to the one advocated for the psychotherapist in Chapter 4. Hospital staff members must avoid aloofness and must participate in the patient's interpersonal field in a spontaneous but controlled manner. This capacity to allow oneself to be "sucked in," but only partially, is an extraordinary asset that enables treaters to gain an empathic understanding of the patient's relationship problems (Hoffman and Gill 1988).

Splitting in the Multiple-Treater Setting

One advantage of a multiple-treater setting over individual therapy is that the patient's self and object representations are externalized onto various staff members all at once rather than onto the psychotherapist alone gradually over time. The setting, then, serves as a superb diagnostic and therapeutic tool for understanding the process of splitting (see Chapter 2).

Splitting in hospital treatment has been well described in a number of papers on the intense countertransference evoked by patients with treatment-resistant borderline personality disorder (Burnham 1966; Gabbard 1986, 1989c, 1992b, 1994, 1997; Main 1957). Empirical research suggests that splitting is not unique to borderline patients, however, but rather is characteristic of a wide variety of personality disorders (Allen et al. 1988; Perry and Cooper 1986). Staff members find themselves assuming and defending highly polarized positions against one another with a vehemence out of proportion to the importance of the issue. The patient has presented one self representation to one group of treaters and another self representation to another group of treaters (Burnham 1966; Cohen 1957; Gabbard 1986, 1989c, 1992b, 1994, 1997; Searles 1965). Via projective identification, each self representation evokes a corresponding reaction in the treater that can be understood as an unconscious identification with the projected internal object of the patient. The transference–countertransference paradigm produced by one self–object constellation may differ dramatically from that produced by another. This discrepancy may first manifest itself in a staff meeting in which the patient is being discussed. Staff members may become puzzled by the disparate descriptions being voiced and may ask each other, "Are we talking about the same patient?"

Full-blown splitting of this variety boldly illustrates the time-honored notion that patients recapitulate their internal object world in the hospital

milieu (Gabbard 1989c). Various treaters become unconsciously identified with the patient's internal objects and play out roles in a script that is written by the patient's unconscious. Moreover, because of the element of control inherent in projective identification, there is often an obligatory quality to the treaters' responses. They feel compelled to behave "like someone else." If projective identification were not involved, the purely intrapsychic splitting that would result would cause little disturbance in the staff group, nor would the staff group view the process as an instance of splitting, because they would probably not feel polarized and angry toward one another.

The splitting that occurs in hospital treatment represents a special instance in which both intrapsychic and interpersonal splitting develop simultaneously (Hamilton 1988). The interpersonal aspects of splitting that occur in staff groups clearly parallel the intrapsychic splitting in the patient. Projective identification is the vehicle that converts intrapsychic splitting into interpersonal splitting.

Staff members who are singled out as recipients of projected internal objects of the patient are not randomly selected. Certain patients have an uncanny ability to detect preexisting latent conflict among various staff members, and their projections may be guided accordingly. A vignette from an actual case (Gabbard 1989c) illustrates this pattern.

> Ms. E, a 26-year-old borderline patient, was admitted to the hospital in a suicidal crisis by her psychotherapist, Dr. F. Ten days after her admission, while she was still voicing suicidal ideation, Dr. F approached Mr. G, the head nurse of the unit, and said he would like to drive Ms. E to the local college campus so she could register for the semester. Mr. G replied that, according to hospital policy, patients who are on suicide precautions may not leave the unit. He suggested that Dr. F might wish to attend a unit staff meeting to further discuss the management of the patient. When Mr. G explained to Ms. E that she could not leave the unit to register, she was enraged with Mr. G and accused him of being a "tyrant" who had no regard for the individual needs of patients. She contrasted him with Dr. F, whom she idealized by saying that he was "the only one who understands me." At the ensuing staff meeting, a heated argument developed between Dr. F and Mr. G, who acted as a spokesperson for the unit staff. In the midst of this clash, Mr. G told Dr. F that the latter was well known for his contempt toward hospital policies and for his propensity to treat patients as "special." As a rebuttal to that accusation, Dr. F informed Mr. G that of all the nurses in the hospital, he was known as the most rigid and punitive.

This example demonstrates how splitting and projective identification do not occur in a vacuum. Ms. E clearly selected individuals who conveniently fit the internal object–relationship paradigms assigned to them. As several authors (Adler 1985; Burnham 1966; Shapiro et al. 1977) have noted, there is often a kernel of reality in the assignment of internal object projections to

staff members. This vignette also reflects an observation by Burnham (1966) that the cleavage is usually between those treaters who emphasize the administrative frame of reference (i.e., what is good for the group) and those who emphasize an individualistic frame of reference based on what is good for an individual patient. Another typical feature of this arrangement is that, in psychotherapy sessions, the patient may omit information deriving from day-to-day unit activities and instead focus exclusively on childhood memories and transference material (Adler 1985; Kernberg 1984). The psychotherapist then has no awareness of the problematic interactions on the unit and is caught by surprise when nursing staff focus attention on them.

As a result of this form of splitting, Adler (1985) noted that the treatment staff may actually exclude the psychotherapist from the process of treatment planning. In this manner the unit staff members may consolidate their alliance by projecting "badness" and incompetence outside the unit group onto the psychotherapist. If this process continues unchecked, it becomes impossible for the unit staff and the psychotherapist to reconcile their differences and meet halfway. Like the patient's internal objects, these two sides of the treatment team cannot be integrated. The regressive power of groups is well known and may result in the use of splitting and projective identification in otherwise well-integrated professionals (Bion 1961; Kernberg 1984; Oldham and Russakoff 1987).

The intensive utilization review process associated with managed care also serves as a convenient nidus for splitting. Treatment staff may attempt to cement an alliance with the patient by externalizing all potential anger and aggression. The managed care reviewer is a natural and convenient repository for all negative feelings that may be felt between treaters and the patient. Hence, the insurance reviewer may be cast in the role of the "bad object" by both the patient and treaters, who can commiserate about their victimization by the reviewer while avoiding any direct discussion of transference-countertransference anger and aggression (Gabbard et al. 1991).

When a staff group reaches this point of fragmentation, all too often the patient is blamed for attempting to divide and conquer (Rinsley 1980). What is often forgotten under these circumstances is that splitting is an unconscious process patients employ automatically to maintain their emotional survival. We do not generally blame patients for other defense mechanisms. The unique issue in splitting seems to be the treaters' perception that the patient is being consciously and maliciously destructive. An empathic frame of reference is useful for reminding staff members that splitting is the patient's attempt to ward off destructiveness for personal protection.

To summarize, splitting in a multiple-treater setting involves four primary features: 1) the process occurs at an unconscious level; 2) the patient perceives individual staff members in dramatically different ways, based on

projections of the patient's internal object representations, and treats each staff member differentially according to those projections; 3) staff members react to the patient, via projective identification, as though they actually are the projected aspects of the patient; and 4) as a result, treaters assume highly polarized positions in staff discussions about the patient and defend those positions with extraordinary vehemence (Gabbard 1989c).

Management of Splitting in the Multiple-Treater Setting

Any discussion of how to manage splitting must begin with Burnham's (1966) caveat that the complete prevention of splitting is neither possible nor desirable. As with other defense mechanisms, splitting provides a safety valve that protects patients from what they perceive as overwhelming danger. It is a process that will develop regardless of preventive measures implemented by treaters. The essential point is that treatment staff must continuously monitor splitting to prevent it from destroying the treatment, devastating the morale of the staff, and irreparably damaging certain interstaff relationships. Instances of serious psychiatric morbidity and staff resignations have resulted from such situations (Burnham 1966; Main 1957).

Education is one important way to help staff manage splitting. All mental health professionals working with seriously disturbed patients should be thoroughly conversant with the concept of splitting and its variants. If staff members cannot recognize splitting when it develops, managing the situation may be hopeless. In discussions of countertransference, staff members can be encouraged to work toward containing projected aspects of the patient rather than acting on them. Intense feelings toward patients should be viewed as useful material for discussion and supervision rather than as forbidden reactions that must be concealed from supervisors. By developing an understanding of the mechanism of splitting, staff members can learn to avoid exploiting it by refusing to accept idealization that would collude with the devaluation of other staff members (Adler 1973; Shapiro et al. 1977). Staff members must also learn to monitor their countertransference tendencies to project aspects of themselves onto the patient.

Education is only a beginning, however. A spirit of open communication about differences should be established and monitored by the staff. Many years ago, Stanton and Schwartz (1954) persuasively demonstrated the prophylactic value of ferreting out and discussing covert staff disagreements. Psychotherapists must view themselves as part of the treatment team and ally themselves with the administrative decisions of the unit team (Adler 1985). Rigid adherence to concerns about confidentiality may feed right into the patient's splitting tendencies.

One primary goal in the treatment of patients with major character pathology is the integration of split self and object representations. To this end, it is often useful to have the staff member identified with the bad object and the treater identified with the good object meet jointly with the patient to frankly discuss the patient's perception of what is going on. This arrangement makes it more difficult for the patient to maintain polarized views because both treaters are acting human and reasonable. Moreover, treaters who are faced with this situation ordinarily become less polarized and move toward middle ground. The very separateness demanded by the splitting mechanism is undermined. Although this confrontation may temporarily increase the patient's anxiety, it also conveys the message that negative feelings can be contained within interpersonal relationships without disastrous consequences.

When the situation is so emotionally charged that the participants are not willing to meet, an objective consultant can be brought in to mediate the discussion (Gabbard 1986). The consultant can fulfill the role of an observing ego for the group and thereby encourage those individuals involved with the splitting to identify with that function.

These meetings presuppose a recognition by all parties of an ongoing splitting process. Such acknowledgment constitutes a major step toward successful management of the splitting. Ordinarily, staff members will be considerably reluctant to see themselves as involved in splitting. When a special meeting is called to discuss the staff dynamics around a particular patient, there may be strong resistance on the part of treaters because such a meeting might make the patient seem too special (Burnham 1966). Rather than viewing the staff meeting as a productive way to discuss a splitting process, an idealized treater may be convinced that he or she is right while everyone else is wrong. Being idealized can be so gratifying that one may not wish to examine the idealization as part of a defensive process in the patient (Finell 1985). This approach will, of course, infuriate the staff even further and widen the split.

When a staff meeting is called to discuss potential splitting, all parties should certainly approach one another with the assumption that they are all reasonable and competent clinicians who care about the patient's welfare. When this approach works, the group feels that each staff member has brought a piece of the puzzle so that the whole becomes more clear (Burnham 1966). However, some splits seem irreparable, and just as the internal objects of the patient cannot be integrated, neither can the external objects reconcile with one another.

The earlier that splitting is discovered, the less entrenched and the more amenable to change it will be. Certain warning signals should be continually monitored in staff meetings: 1) when a treater is uncharacteristically puni-

tive toward a patient, 2) when a treater is unusually indulgent, 3) when one treater repeatedly defends a patient against critical comments from other staff members, and 4) when one staff member believes that no one else can understand the patient (Gabbard 1989c).

When staff members can swallow their pride and accept that they may be involved in an unconscious identification with projected aspects of the patient, they can begin to empathize with their fellow staff members' feelings and perspectives. This willingness to consider someone else's point of view can lead to collaborative work on behalf of the patient that results in marked improvement in the splitting process. The patient's internal split often begins to mend at the same time the staff's external cleavage heals (Gabbard 1986). These parallel developments may be understood as the third step of projective identification—the previously split-off and projected object representations of the patient have been contained and modified by the treaters and have then been reintrojected (in modified form) by the patient in a meaningful interpersonal context. By approaching their own differences in good faith, staff members can provide an atmosphere in the milieu where good experiences predominate over bad ones—an essential condition for facilitating the integration of love and hate in the patient.

Role of Group Treatment in the Milieu

The foregoing descriptions of the introjection and projection of self and object representations illustrate the need for careful monitoring of group process on every psychiatric unit. Frequent staff meetings are essential for integrating the split-off fragments circulating among staff members and patients. Similarly, regular group meetings with patients promote a careful processing of interactions between the staff and patients and among patients themselves; they also serve to prevent acting out of conflicts that develop in these relationships. Object relations theory provides a good conceptual framework for understanding group process on the unit (Kernberg 1973, 1984; Oldham and Russakoff 1987). Stanton and Schwartz (1954) illustrated how dynamics in the patient group may directly reflect similar dynamics in the staff group. Specifically, it is common for individual patients to act out covert staff conflicts. Systematic processing of interpersonal conflicts both in staff meetings and in meetings of patients and staff can be valuable in identifying parallel processes in the two groups.

The actual focus of small patient groups in the hospital inpatient unit or day hospital varies depending on the ego strengths and the diagnostic categories of the patients on a particular unit. In general, however, psychothera-

peutic group meetings serve as an interface between the patients' intrapsychic difficulties and their conflicts in the milieu. Kibel (1987) suggested that the focus of such groups should be on the interpersonal difficulties that emerge in daily life on the hospital unit. These difficulties can be linked to the patients' intrapsychic conflicts or deficiencies. He suggested deemphasizing transference in such groups because the anxiety generated by transference work might overwhelm both the individual and collective egos of the group. Horwitz (1987), on the other hand, believed that transference focus may be of value in inpatient groups by serving to strengthen the therapeutic alliance within the group. When small group meetings are properly conducted, they may also become havens or sanctuaries in which patients can ventilate their feelings about the experience of being a psychiatric inpatient and in which staff members can, in turn, validate those feelings and experiences (Kibel 1987). More specific use of inpatient groups is discussed in Section II of this volume in the context of distinct diagnostic entities.

Indications for a Dynamically Informed Approach

A potential objection to the model of treatment presented in this chapter is that a conceptual framework based on the modification of object relations is not applicable to brief treatment in the same way that it is to extended hospital treatment. The fallacy in this argument is the conceptualization of the hospital treatment as occurring in a vacuum rather than as existing as one segment of a continuous effort over many months or years. There is a cumulative effect of many different disconfirmations of the unconscious expectations of the patient over time. Only with repeated failure to provoke the same pattern of responses in treaters do patients ultimately begin to assimilate and internalize the new object relations presented to them. Staff members of an inpatient unit or a partial hospitalization service, the psychotherapist, and friends and family may ultimately provide enough new experiences and responses to strengthen the patient's ego and improve his or her object relations to a level of increased functioning in society.

Serious treatment errors can be inflicted on the patient just as easily in a short-term setting as in a long-term setting. A sophisticated psychodynamic understanding of the patient assists the treaters in their efforts to avoid errors of technique. They may avoid, for example, the pitfall of colluding with the patient's passive stance vis-à-vis treatment. A fundamental dynamic notion is that the patient is a collaborator in the treatment process. Psychodynamically informed treatment encourages patients to reflect on connections between their present situation and childhood antecedents so that they can

begin to understand how they are perpetuating patterns that were scripted long ago. Intimately connected with this notion is the idea that patients are capable of taking active steps to change their situation.

In Sigmund Freud's (1914/1958) original usage of the term *acting out,* he was noting the transference tendency of patients to repeat in action something from the past rather than to remember and verbalize it. The same phenomenon occurs in inpatient or day hospital treatment, where patients repeat their characteristic mode of engaging others in an attempt to gratify their needs and wishes. Another basic psychodynamic notion is that patients must move in the direction of reflecting and talking about their internal experience rather than automatically allowing it to thrust them into action. Those patients who, for reasons of cognitive dysfunction, low intelligence, or psychotic withdrawal, cannot enter into a productive verbal interchange with staff members can nevertheless benefit from the nonverbal experiential aspects of new forms of object relatedness. As Ogden (1986) stressed, a treatment does not have to be verbal to be psychoanalytic in nature.

Evidence has been accumulating that psychoanalytically informed hospital treatment is effective, particularly for personality disorders (Dolan et al. 1997; Gabbard et al. 2000). Data suggest that aftercare treatment may be equally important for good outcomes. Chiesa et al. (2003) compared two models of psychosocial intervention for personality disorders. Patients were naturalistically allocated to either extended inpatient treatment of 1 year with no specialist outpatient treatment following discharge or 6 months of inpatient treatment followed by 18 months of twice-weekly outpatient psychoanalytically oriented therapy and 6 months of psychosocial outreach nursing in the community. A third group was a matched sample of patients with personality disorder who received standard psychiatric care without psychotherapy. The two groups of patients exposed to the psychoanalytically informed treatment showed highly significant improvement after 2 years, whereas the general psychiatric group, who did not receive such treatment, remained substantially unchanged. When the patients who received only the extended inpatient treatment were compared with the patients in the two-stage model, those with briefer inpatient stays followed by outpatient treatment had superior outcomes.

In the most sophisticated study of psychoanalytically informed day hospital treatment, Bateman and Fonagy (1991, 2001) randomly assigned 38 patients with borderline personality disorder to either partial hospitalization or general psychiatric care. Patients in the day hospital group showed much better outcomes on all measures and continued to improve after treatment ended. Their treatment was also highly cost effective compared with the general psychiatric care that others received (Bateman and Fonagy 2003).

Combined Treatment in Outpatient Settings

Although the chapter thus far has focused primarily on the multiple-treater settings in inpatient units or partial hospital programs, perhaps the most common situation encountered in outpatient psychiatry that involves multiple treaters is when a psychiatrist is prescribing and another clinician is conducting psychotherapy. In many cases, of course, one psychiatrist both prescribes medication and takes responsibility for the psychotherapy. However, this *one-person* model may be on the decline. Managed care companies tend to reimburse psychiatrists at more favorable rates if they practice medication management rather than psychotherapy. In a study of office-based psychiatrists in terms of the provision of psychotherapy, Mogtabai and Olfson (2008) found that psychotherapy was provided in only 28.9% of visits in 2004–2005, a significant decline from 44.4% of visits in 1996–1997. Today it is most common for a psychiatrist to prescribe while another mental health professional conducts the psychotherapy.

This *two-person* model may have some advantages in that the two treaters can consult with one another on difficult cases, and the intensity of the transference may be diluted in some situations. However, in many cases, communication does not occur because the time spent consulting with the other treaters is not reimbursed by a third party or managed care company (Gabbard 2000). As a result, collegial discussions are relegated to low priority in the clinician's list of things that must be done. Moreover, in some managed care settings, the psychotherapist and the pharmacotherapist are assigned according to who is on an insurance panel, and the two clinicians may have never met one another and may have no interest in collaborating. This absence of communication may produce another form of splitting as in the following example:

> Ms. H was a 29-year-old patient with borderline personality disorder who saw a psychiatrist for medication and a psychologist for psychotherapy. In one session with her psychiatrist, who was prescribing a serotonin reuptake inhibitor for her, she told him, "I probably shouldn't say this, but my psychotherapist is screaming at me during the sessions." The psychiatrist was disturbed to hear that a fellow mental health professional was behaving in that way. He asked Ms. H if he had her permission to call and speak to the therapist. She said she would be happy to give that permission.
>
> When the psychiatrist called the psychologist, he informed his colleague about what Ms. H was saying about him. The psychologist said, "I'm glad you called because I felt some splitting was developing between us." Then, in a low but audible voice, he said, "You hear the volume I'm speaking in right now? When I speak to her at that level, she will say 'Stop yelling at me.'" The psychiatrist responded by saying, "Really? She considers that screaming?"

> The psychologist replied, "I know it seems ridiculous, but she was so sensitive to being yelled at as a child that she is inclined to view me as exactly like one of her parents who was berating her. So I have to talk in almost a whisper for her not to feel that I'm shouting at her." The psychiatrist felt that his colleague was in a real dilemma and empathized with him instead of thinking critically that he needed to be corrected. He said, "I can appreciate how difficult that would be. Do I have your permission to talk with her about this conversation?" The psychologist responded, "Yes, of course. I would really appreciate that." In the next session, Ms. H's psychiatrist conveyed to her what he had heard from the psychologist. Ms. H became defensive and responded by saying, "It feels like screaming to me." Her psychiatrist responded, "I know it does, but that's the point. It's a perception based on your past experiences."

In this vignette, Ms. H's psychiatrist was able to detect a splitting process that was developing and deal with it more constructively by calling his therapist colleague and having a frank discussion about what was going on. Even if there is no reimbursement by a third party for these collegial conversations, they are essential in the treatment of more difficult patients to prevent a disruptive splitting process. Perhaps the best preventive approach is to set up an explicit discussion at the beginning of treatment between psychotherapist and prescriber (Meyer and Simon 1999; Gabbard 2000). There should be frank discussion about who is responsible for the patient's safety and treatment in a crisis, an agreement to inform each other when significant changes in the treatment are being contemplated, and the establishment of clear communication about when one is out of town or unavailable. Goldberg and Ernst (2012) suggest that the therapist may wish to redirect the patient to the prescribing psychiatrist when the patient brings up concerns about medication, thus strengthening the message about the division of labor. The patient must understand that the two treaters are part of a treatment team who must feel free to talk with each other. Hence, consent must be given by the patient for the two colleagues to converse. Busch and Sandberg (2007) point out that confidentiality concerns are sometimes not adequately discussed with the patient, and either clinician may simply assume that the patient knows that the two treaters talk periodically. Hence, there is a need to make this explicit in meetings with the patient. Busch and Sandberg also point out that when each clinician practices according to a different theoretical model, it can lead to disruptions in the implementation of the treatment. The two treaters may unwittingly be conveying a two-illness model to the patient by the way they talk about the causes and necessary treatments of the patient's condition. The reconciliation of the two models is another compelling reason for there to be discussion between the two treaters, both initially and as problems develop. Finally, there should be an initial agreement that if either one of the treaters wishes to terminate his or her role in the treatment, provision will be made for another clinician as a replacement.

References

Adler G: Hospital treatment of borderline patients. Am J Psychiatry 130:32–36, 1973

Adler G: Borderline Psychopathology and Its Treatment. New York, Jason Aronson, 1985

Adshead G: Psychiatric staff as attachment figures. Br J Psychiatry 172:64–69, 1998

Allen JG, Deering CD, Buskirk JR, et al: Assessment of therapeutic alliances in the psychiatric hospital milieu. Psychiatry 51:291–299, 1988

Bateman AW, Fonagy P: The effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. Am J Psychiatry 156:1563–1569, 1991

Bateman AW, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry 158:36–42, 2001

Bateman AW, Fonagy P: Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. Am J Psychiatry 160:169–171, 2003

Bion WR: Experiences in Groups and Other Papers. New York, Basic Books, 1961

Burnham DL: The special-problem patient: victim or agent of splitting? Psychiatry 29:105–122, 1966

Busch FN, Sandberg LS: Psychotherapy and Medication: The Challenge of Integration. New York: Analytic Press, 2007

Casement PJ: The meeting of needs in psychoanalysis. Psychoanalytic Inquiry 10:325–346, 1990

Chiesa M, Fonagy P, Holmes J: When more is less: an exploration of psychoanalytically oriented hospital-based treatment for severe personality disorder. Int J Psychoanal 84:637–650, 2003

Cohen RA: Some relations between staff tensions and the psychotherapeutic process, in The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behavior. Edited by Greenblatt M, Levinson DJ, Williams RH. Glencoe, IL, Free Press, 1957, pp 301–308

Dolan B, Warren F, Norton K: Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. Br J Psychiatry 171: 274–279, 1997

Finell JS: Narcissistic problems in analysts. Int J Psychoanal 66:433–445, 1985

Freud S: Remembering, repeating and working-through (further recommendations on the technique of psycho-analysis II) (1914), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 145–156

Gabbard GO: The treatment of the "special" patient in a psychoanalytic hospital. International Review of Psychoanalysis 13:333–347, 1986

Gabbard GO: A contemporary perspective on psychoanalytically informed hospital treatment. Hosp Community Psychiatry 39:1291–1295, 1988

Gabbard GO: On "doing nothing" in the psychoanalytic treatment of the refractory borderline patient. Int J Psychoanal 70:527–534, 1989a

Gabbard GO: Patients who hate. Psychiatry 52:96–106, 1989b

Gabbard GO: Splitting in hospital treatment. Am J Psychiatry 146:444–451, 1989c

Gabbard GO: Comparative indications for brief and extended hospitalization, in American Psychiatric Press Review of Psychiatry, Vol 11. Edited by Tasman A, Riba MB. Washington, DC, American Psychiatric Press, 1992a, pp 503–517

Gabbard GO: The therapeutic relationship in psychiatric hospitalization. Bull Menninger Clin 56:4–19, 1992b

Gabbard GO: Treatment of borderline patients in a multiple-treater setting. Psychiatr Clin North Am 17:839–850, 1994

Gabbard GO: Training residents in psychodynamic psychiatry, in Acute Care Psychiatry: Diagnosis and Treatment. Edited by Sederer LI, Rothschild AJ. Baltimore, MD, Williams & Wilkins, 1997, pp 481–491

Gabbard GO: Treatment-resistant borderline personality disorder. Psychiatric Annals 28:651–656, 1998

Gabbard GO: Combining medication with psychotherapy in the treatment of personality disorders, in Psychotherapy for Personality Disorders. Edited by Gunderson JG, Gabbard GO. Washington, DC, American Psychiatric Publishing, 2000, pp 65–93

Gabbard GO, Wilkinson SM: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press, 1994

Gabbard GO, Takahashi T, Davidson JE, et al: A psychodynamic perspective on the clinical impact of insurance review. Am J Psychiatry 148:318–323, 1991

Gabbard GO, Coyne L, Allen JG, et al: Evaluation of intensive inpatient treatment of patients with severe personality disorders. Psychiatr Serv 51:893–898, 2000

Goldberg JF, Ernst CL: Managing the Side Effects of Psychotropic Medication. Washington, DC, American Psychiatric Publishing, 2012

Hamilton NG: Self and Others: Object Relations Theory in Practice. Northvale, NJ, Jason Aronson, 1988

Harty MK: Countertransference patterns in the psychiatric treatment team. Bull Menninger Clin 43:105–122, 1979

Hilles L: Changing trends in the application of psychoanalytic principles to a psychiatric hospital. Bull Menninger Clin 32:203–218, 1968

Hoffman IZ, Gill MM: Critical reflections on a coding scheme. Int J Psychoanal 69:55–64, 1988

Horwitz L: Transference issues in hospital groups. Yearbook of Psychoanalysis and Psychotherapy 2:117–122, 1987

Kernberg OF: Psychoanalytic object-relations theory, group processes and administration: toward an integrative theory of hospital treatment. Annual of Psychoanalysis 1:363–388, 1973

Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984

Kibel HD: Inpatient group psychotherapy: where treatment philosophies converge. Yearbook of Psychoanalysis and Psychotherapy 2:94–116, 1987

Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971

Main TF: The ailment. Br J Med Psychol 30:129–145, 1957

Menninger WC: The Menninger Hospital's Guide to the Order Sheet (1939). Bull Menninger Clin 46:1–112, 1982

Meyer DJ, Simon RI: Split treatment: clarity between psychiatrists and therapists, part I. Psychiatr Ann 29:241–245, 1999

Mogtabai R, Olfson M: National trends in psychotherapy by office-based psychiatrists. Arch Gen Psychiatry 65:962–970, 2008

Ogden TH: Projective Identification and Psychotherapeutic Technique. New York, Jason Aronson, 1982

Ogden TH: The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue. Northvale, NJ, Jason Aronson, 1986

Oldham JM, Russakoff LM: Dynamic Therapy in Brief Hospitalization. Northvale, NJ, Jason Aronson, 1987

Perry JC, Cooper SH: A preliminary report on defenses and conflicts associated with borderline personality disorder. J Am Psychoanal Assoc 34:863–893, 1986

Pine F: Drive, Ego, Object, and Self: A Synthesis for Clinical Work. New York, Basic Books, 1990

Poggi RG, Ganzarain R: Countertransference hate. Bull Menninger Clin 47:15–35, 1983

Rinsley DB: Treatment of the Severely Disturbed Adolescent. New York, Jason Aronson, 1980

Rinsley DB: Borderline and Other Self Disorders: A Developmental and Object-Relations Perspective. New York, Jason Aronson, 1982

Sandler J, Sandler AM: On the development of object relations and affects. Int J Psychoanal 59:285–296, 1978

Searles HF: Collected Papers on Schizophrenia and Related Subjects. New York, International Universities Press, 1965

Searles HF: The "dedicated physician" in the field of psychotherapy and psychoanalysis (1967), in Countertransference and Related Subjects. Madison, CT, International Universities Press, 1979, pp 71–88

Shapiro ER, Shapiro RL, Zinner J, et al: The borderline ego and the working alliance: indications for family and individual treatment in adolescence. Int J Psychoanal 58:77–87, 1977

Simmel E: Psycho-analytic treatment in a sanatorium. Int J Psychoanal 10:70–89, 1929

Stamm I: Countertransference in hospital treatment: basic concepts and paradigms. Bull Menninger Clin 49:432–450, 1985a

Stamm I: The hospital as a "holding environment." International Journal of Therapeutic Communities 6:219–229, 1985b

Stanton AH, Schwartz MS: The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment. New York, Basic Books, 1954

Symington N: The possibility of human freedom and its transmission (with particular reference to the thought of Bion). Int J Psychoanal 71:95–106, 1990

Weiss J, Sampson H, the Mount Zion Psychotherapy Research Group: The Psychoanalytic Process: Theory, Clinical Observations, and Empirical Research. New York, Guilford, 1986

Wesselius LF: Countertransference in milieu treatment. Arch Gen Psychiatry 18:47–52, 1968

Winnicott DW: The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. London, Hogarth Press, 1965

Zee HJ: Purpose and structure of a psychoanalytic hospital. J Natl Assoc Priv Psychiatr Hosp 84:20–26, 1977

SECTION II

DYNAMIC APPROACHES TO DSM-5 DISORDERS

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CHAPTER 7

SCHIZOPHRENIA

> There is no developmental period when the human exists outside of the realm of interpersonal relatedness.
>
> *Harry Stack Sullivan*

Genetic factors play a major role in the development of schizophrenia. The best-controlled studies suggest a concordance for schizophrenia in monozygotic twins of between 40% and 50%, whereas the concordance in dizygotic twins is roughly similar to that found in siblings (Kety 1996; Plomin et al. 1990). There is likely to be some genetic heterogeneity—in other words, there is probably more than one defective gene involved and more than one genetic picture underlying the disorder. Incomplete penetrance is likely to apply as well, because less than half of monozygotic twin pairs are concordant. Environmental factors also appear to be involved in the development of schizophrenia, although there is not yet a consensus on the exact nature of these environmental insults. Research efforts suggest that being raised in an urban environment (Pedersen and Mortensen 2001) and childhood head injury (Abdelmalik et al. 2003) may both increase one's risk of developing schizophrenia. One population-based study suggested that severe stress to a mother during the first trimester may alter the risk of schizophrenia in offspring (Khashan et al. 2008). These investigators postulated that severe stressors in

the environment may interact with combined effects of multiple susceptibility genes to influence neurodevelopment at the fetoplacental-maternal interface.

None of the findings of biological research attenuates the impact of one irreducible fact—schizophrenia is an illness that happens to a person with a unique psychological makeup. Even if genetic factors accounted for 100% of the etiology of schizophrenia, clinicians would still be faced with a dynamically complex individual reacting to a profoundly disturbing illness. Sophisticated psychodynamic approaches to the management of the schizophrenic patient will always continue to be vital components of the clinician's treatment armamentarium.

There is no such thing as *the* treatment of schizophrenia. All therapeutic interventions must be tailored to the unique needs of the individual patient. Schizophrenia is a heterogeneous illness with protean clinical manifestations. One helpful organization of the descriptive symptomatology of the disorder is a division into three clusters: 1) positive symptoms, 2) negative symptoms, and 3) disordered personal relationships (Andreasen et al. 1982; Keith and Matthews 1984; Munich et al. 1985; Strauss et al. 1974). First proposed by Strauss et al. (1974), this model distinguishes three discrete psychopathological processes found in schizophrenic patients. This classification is one of several that have been suggested. Some propose that the third cluster should comprise mental or cognitive disorganization symptoms. I have chosen to focus on disordered personal relationships because of their relevance to a psychodynamically informed treatment approach. Positive symptoms include disturbances of thought content (such as delusions), disturbances of perception (such as hallucinations), and behavioral manifestations (such as catatonia and agitation) that develop over a short time and often accompany an acute psychotic episode.

Whereas the florid positive symptoms constitute an undeniable "presence," the negative symptoms of schizophrenia are better categorized as an "absence" of function. These negative symptoms include restricted affect, poverty of thought, apathy, and anhedonia. Patients in whom a negative symptom picture predominates can be characterized by a number of features that suggest structural brain abnormality, including poor premorbid adjustment, poor school performance, greater difficulty holding jobs, poor performance on cognitive testing, poor treatment response, early age at onset, and premorbid difficulties in social and instrumental functioning (Andreasen et al. 1990).

Carpenter et al. (1988) suggested a further distinction among negative symptoms. They pointed out that certain forms of social withdrawal, blunted affect, and apparent impoverishment of thought may actually be secondary to anxiety, depression, environmental deprivation, or drug effects. These manifestations should therefore not be labeled *negative symptoms* because

they are short-lived and secondary. Carpenter et al. (1988) proposed the term *deficit syndrome* to refer to clearly primary negative symptoms that endure over time. Duration of negative symptoms is also prognostically significant. Kirkpatrick et al. (2001) stressed that deficit pathology defines a group of patients with a disease that is fundamentally different from schizophrenia without deficit features. They pointed out that the deficit illness has a different course, different biological correlates, and different treatment response.

Like negative symptoms, disordered personal relationships tend to develop over a long period. These problems grow out of a characterological substrate and include myriad interpersonal difficulties as varied as the range of human personality. Prominent manifestations of disordered interpersonal relationships include withdrawal, inappropriate expressions of aggression and sexuality, lack of awareness of the needs of others, excessive demandingness, and inability to make meaningful contact with other people.

Keshavan and Eack (2014) suggested that psychotherapy planning is aided by considering the typical sequence of phases that characterizes the course of schizophrenia. In the premorbid phase, cognitive and social difficulties are identifiable through much of childhood. In the prodromal phase there are cognitive and social declines as well as changes in thought, personality, and mood with subthreshold symptoms that have psychotic-like character to them. In the psychotic phase, florid positive symptoms such as delusions and hallucinations appear. A transitional or recovery phase may last months to years and is characterized by ambivalence about treatment, a tendency to relapse under stress, and comorbid depression and anxiety. The stable or chronic phase typically includes persistent negative symptoms, remissions and exacerbations in psychotic symptoms, and cognitive deficits. These investigators stressed that the goals of psychotherapy may vary across the phases of the illness. Prevention of psychosis and reduction of prodromal symptoms are the key goals during the prodrome. In the psychotic phase reduction of psychosis severity and duration and support are central. Critical to the transitional phase is prevention of relapse and comorbidity. Finally, rehabilitation and reintegration into the community are the core goals of the stable, chronic phase. Hence, any psychotherapeutic approach needs to be tailored to the main problems in the clinical presentation of the patient.

Psychodynamic Understanding of Schizophrenia

Many psychodynamic models have been proposed to assist clinicians in understanding the schizophrenic process. The conflict-versus-deficit controversy (described in Chapter 2) is a prominent feature in discussions of theories of schizophrenia. Freud himself vacillated between a conflict model

and a deficit model of schizophrenia as his own conceptualization evolved (Arlow and Brenner 1969; Grotstein 1977a, 1977b; London 1973a, 1973b; Pao 1973). Much of Freud's (1911/1958, 1914/1963, 1915/1963, 1924a/1961, 1924b/1961) conceptualization developed out of his notion of cathexis, which referred to the quantity of energy attached to any intrapsychic structure or object representation. He was convinced that schizophrenia was characterized by a decathexis of objects. At times he used this concept of decathexis to describe a detachment of emotional or libidinal investment from intrapsychic object representations; at other times he used the term to describe social withdrawal from real persons in the environment (London 1973a). Freud defined schizophrenia as a regression in response to intense frustration and conflict with others. This regression from object relatedness to an autoerotic stage of development was accompanied by a withdrawal of emotional investment from object representations and from external figures, which explained the appearance of autistic withdrawal in schizophrenic patients. Freud (1914/1963) postulated that the patient's cathexis was then reinvested in the self or ego.

Some authors (London 1973a, 1973b; Wexler 1971) have viewed Freud's decathexis theory as an acknowledgment of a deficit model of schizophrenia, although Freud clearly attempted to take conflict into account as well. After developing the structural model, he revised his view of psychosis accordingly (Freud 1924a/1961, 1924b/1961). Whereas he viewed neurosis as a conflict between the ego and the id, he regarded psychosis as a conflict between the ego and the external world. Psychosis involved a disavowal and subsequent remodeling of reality. Despite this revision, Freud continued to speak of the withdrawal of cathexis and its reinvestment in the ego. He used the withdrawal of object cathexis to explain his observation that, compared with neurotic patients, schizophrenic patients were incapable of forming transferences.

Freud's notion that schizophrenic patients do not form transference attachments was undoubtedly related to the fact that he did not attempt intensive therapeutic efforts with such patients. Harry Stack Sullivan, on the other hand, devoted his life to the treatment of schizophrenia and arrived at very different conclusions. He believed that the etiology of the disorder resulted from early interpersonal difficulties (particularly in the child–parent relationship), and he conceptualized the treatment as a long-term interpersonal process that attempted to address those early problems. According to Sullivan (1962), faulty mothering produced an anxiety-laden self in the infant and prevented the child from having its needs satisfied. This aspect of the self experience was then dissociated, but the damage to self-esteem was profound. The onset of the schizophrenic illness, in Sullivan's view, was a resurgence of the dissociated self that led to a panic state and then psychotic

disorganization. Sullivan always considered the capacity for interpersonal relatedness to be present in even the most withdrawn schizophrenic patient. His pioneering work with schizophrenic patients was carried on by his disciple, Frieda Fromm-Reichmann (1950), who stressed that schizophrenic persons are not happy with their withdrawn state. They are fundamentally lonely people who cannot overcome their fear and distrust of others because of adverse experiences early in life.

While Sullivan and his followers were developing their interpersonal theories, early ego psychologists were observing that a faulty ego boundary is one of the chief deficits in schizophrenic patients. Federn (1952) did not agree with Freud's assertion that object cathexis was withdrawn in schizophrenia. Instead, Federn emphasized the withdrawal of ego boundary cathexis. He noted that schizophrenic patients characteristically have no barrier between what is inside and what is outside, because their ego boundary is no longer psychologically invested (as it is in neurotic patients).

Many of these early psychoanalytic formulations created profound difficulties between the clinicians treating patients with schizophrenia and the families of those patients. Terms such as *schizophrenogenic mother* generated an atmosphere in which mothers felt blamed for causing schizophrenia in their children. In subsequent decades, more sophisticated psychodynamic formulations of schizophrenia appeared (Arlow and Brenner 1969; Blatt and Wild 1976; Grand 1982; Grotstein 1977a, 1977b; Mahler 1952; Ogden 1980, 1982). Most of these theories are based on reconstructions from working with adult patients. In other words, the clinicians have studied the mental processes in the psychotherapeutic setting and then extrapolated backward into childhood developmental issues. Unfortunately, many of the psychoanalytic formulations do not integrate findings from biological research into their theories of etiology.

Several psychological configurations reflect the interface between the neurobiological and the psychological. Children who ultimately develop schizophrenia have an aversion to object relations that make bonding with them difficult. Hypersensitivity to stimulation and difficulties with attention and concentration also are common preschizophrenia personality traits. Research has suggested that regionally diffuse losses of normal sensory gating in the central nervous system may be characteristic of schizophrenia (Freedman et al. 1996; Judd et al. 1992), so that patients find it difficult to screen out irrelevant stimuli and, as a consequence, feel a chronic sense of sensory overload. Robbins (1992) suggested a correlation between emotional states of mental oblivion and findings of cortical atrophy and decreased activity in the frontal lobes of schizophrenic patients. This cluster of features taken together leads to complicated challenges for parents and caretakers who must adapt to the demands of such children. In an elegantly designed prospective

study (Cannon et al. 2002), significant impairments in neuromotor, receptive language, and cognitive development in childhood predicted schizophreniform disorder.

Theories of etiology and pathogenesis must take into account the substantial evidence that genetic factors play a key role. In the absence of such factors, even highly dysfunctional family situations will not produce schizophrenic illness in the offspring (Wahlberg et al. 1997). One of the most compelling hypotheses is that of Kendler and Eaves (1986), who postulated that genes control the degree to which an individual is sensitive to the environment's predisposing, risk-increasing aspects versus its risk-reducing and protective aspects. Indeed, compared with control subjects, patients with higher levels of familial risk for psychosis react with greater emotional intensity to daily life stress (Myrin-Germeys et al. 2001). This theory of genetic control of sensitivity to the environment was supported by a Finnish study in which a group of 58 adoptees with schizophrenic biological mothers was compared with a group of 96 comparison adoptees at ordinary genetic risk (Wahlberg et al. 1997). Among the offspring of adoptive parents with high levels of communication deviance, a higher proportion of those adoptees at high genetic risk showed evidence of thought disorder compared with the group of comparison adoptees. In this conceptual model, emphasis is placed on the "fit" between child and family. A subgroup of adoptees at high genetic risk did not "fit" with their adoptive parents who were characterized by high communication deviance.

One of the implications of this conceptual model is that a positive rearing experience can protect high-risk individuals against future development of schizophrenia. This view was supported by the Finnish Adoptive Family Study (Tienari et al. 1994). In this investigation, the children of schizophrenic mothers who had a positive adoptive experience were protected from later schizophrenia, whereas the genetically vulnerable individuals who experienced a disturbed adoptive family tended to develop the disorder. In a subsequent report on the adopted-away offspring of the mothers with schizophrenia-spectrum disorders, Tienari and colleagues (2004) visited the adoptees and their adoptive families at home and measured family dysfunction on a scale of "healthy" to "severely dysfunctional." The investigators concluded that those adopted children at high risk were more likely to develop schizophrenia if there was significant family dysfunction. This link was not present in those at low genetic risk. Hence these findings support the notion that there is an interactive effect of genetic risk and rearing environment in schizophrenia.

In a comprehensive review of the literature, Olin and Mednick (1996) identified premorbid characteristics that appear to be risk markers for future psychosis. These characteristics fall into two categories: 1) early etiological

factors, including perinatal complications, family history of schizophrenia, maternal exposure to influenza, neurobehavioral deficits, parental separation in the first year of life, distressed family functioning, and institutional rearing; and 2) behavioral and social precursors of mental illness identified by clinicians and teachers and personality variables revealed by interviews and questionnaires. In other words, an interaction occurs among genetic vulnerability, environmental attributes, and individual traits.

Much of the psychodynamic literature on schizophrenia is focused on treatment considerations. Indeed, psychodynamic understanding is relevant to the treatment of schizophrenia, regardless of its etiology. Certain common threads run through many of the psychodynamic theories that inform the clinician's approach to the patient. First, psychotic symptoms have meaning (Karon 1992). Grandiose delusions or hallucinations, for example, often immediately follow an insult to a schizophrenic patient's self-esteem (Garfield 1985; Garfield et al. 1987). The grandiose content of the thought or perception is the patient's effort to offset the narcissistic injury.

A second theme is that human relatedness is fraught with terror for these patients. The intense anxieties involving contact with others are apparent even though the etiology cannot be entirely explained. Concerns about the integrity of one's ego boundaries and the fear of fusion with others represent an ongoing problem that is often resolved by isolation. Treatment relationships present a challenge for the patient to be able to trust that catastrophe will not result from becoming connected with others. Finally, a third common thread involves the conviction of all psychodynamically oriented authors that dynamically informed therapeutic relationships with sensitive clinicians can fundamentally improve the quality of life for schizophrenic patients. In a study of fully recovered schizophrenic patients (Rund 1990), 80% had been in long-term psychotherapy and had attached great importance to it. Even when full recovery is not achieved, the therapeutic relationship may still be of extraordinary value in the patient's overall adaptation to life.

Treatment Approaches

Pharmacotherapy

Well-designed controlled studies abundantly demonstrate that antipsychotic medication is highly efficacious in managing the positive symptoms of schizophrenia. The schizophrenic patient's accessibility to all other forms of therapeutic intervention is greatly enhanced by the judicious use of antipsychotics. Keith and Matthews (1984) even asserted that "freedom from positive symptoms approaches a sine qua non status for psychosocial treat-

ments" (p. 71). Negative symptoms and disordered interpersonal relationships, however, are much less affected by medication and thus require psychosocial approaches. Some of the new and atypical antipsychotic agents (such as clozapine, risperidone, and olanzapine) appear to make a greater impact on negative symptom constellations.

Because numerous outstanding psychopharmacology texts are available, I focus here on psychosocial approaches to treatment. As discussed in Chapter 5, noncompliance with prescribed medication is an ongoing problem in the treatment of many schizophrenic patients. Dynamic psychiatrists involved in the long-term management of patients with schizophrenia must view medication compliance as a treatment concern. Each patient must be educated about the likelihood of relapse if medication is stopped, about signs of tardive dyskinesia, and about management of the more benign side effects. In addition, the meaning of the medication to the patient must be explored from time to time, particularly at the first sign of noncompliance. As emphasized in Chapter 5, the prescribing of antipsychotic medication must occur in the context of a therapeutic alliance that is carefully fostered through sensitivity to the patient's internal experience of all treatments.

A decade ago, the atypical antipsychotics were enthusiastically received, with the fantasy that they might revolutionize the treatment of schizophrenia. However, as further research has accumulated, there is a growing awareness that the true efficacy of these agents in the treatment of schizophrenia is not greatly different from the conventional antipsychotics. However, the side effect profile is often more benign and therefore makes these agents appealing to both patients and psychiatrists. Clozapine appears to have some advantage over the array of other antipsychotic agents in some cases (Lieberman et al. 2012). For example, in a study comparing patients who received clozapine with those taking a conventional antipsychotic, the clozapine-treated patients were much more likely to participate in psychosocial rehabilitation treatment (Rosenheck et al. 1998).

Many patients with schizophrenia who find themselves improving on some of the new medications have a good deal of difficulty integrating the newly acquired sense of self that emerges with symptomatic improvement. Patients with chronic psychoses may also have been insulated from the risks of intimacy. The remission of psychotic symptoms may open up the possibility of romantic and sexual involvement for the first time in years. Many patients may experience extraordinary anxiety at this prospect. The inherent risks of loss and rejection must be faced when these patients begin to reach out to others (Duckworth et al. 1997). Finally, emergence from psychosis may present patients with an existential crisis about purpose and meaning in life. They recognize that a good portion of their lives has been lost to chronic illness, and they are forced to reassess their personal and spiritual

values. Those who enter the workforce are confronted with integrating the meaning of work into a sense of purpose and personal identity after having been unable to work for extended periods of time.

In addition to skills training, rehabilitation, and other modalities, patients who respond well to atypical antipsychotics also require a supportive human relationship in which these adjustments can be explored.

Individual Psychotherapy

Despite a rich clinical tradition of individual psychoanalytically oriented psychotherapy of schizophrenia, research studies have been hard pressed to demonstrate that the average schizophrenic patient is likely to reap significant benefit from such efforts. The Camarillo State Hospital Study (May 1968) is often cited because it was the first large-scale study that compared outcomes of schizophrenic patients according to whether they were treated with psychotherapy or with antipsychotic medication. The patient groups who received medication showed significantly greater improvement than both those who did not receive it and those who received psychotherapy alone. Moreover, no interactive effect was noted between psychotherapy and antipsychotic medication. This study has been criticized, however, because it relied on inexperienced therapists who had no particular commitment to the type of psychotherapy they were instructed to practice with their research subjects. Also, the outcome measures were not sensitive enough to pick up changes in interpersonal and general psychological functioning that might specifically respond to psychotherapy (Conte and Plutchik 1986). Two other studies that were also fraught with methodological problems (Grinspoon et al. 1972; Rogers et al. 1967) found questionable benefit from psychotherapy. Karon and VandenBos (1981) demonstrated more improvement in schizophrenic patients treated by experienced therapists compared with a control group of patients who received routine treatment with phenothiazines and supportive therapy, but this study has also been criticized for methodological problems, such as a lack of random assignment and early transfer of patients in the drug treatment group to a chronic unit (Keith and Matthews 1984; Klein 1980).

The most elegantly designed study on the effects of dynamic psychotherapy with schizophrenic patients is the Boston Psychotherapy Study reported by Stanton, Gunderson, and colleagues (Gunderson et al. 1984; Stanton et al. 1984). A principal failure in previous studies had been the lack of definition in the form of psychotherapy being administered by project therapists. In the Boston study, nonchronic schizophrenic patients from diverse institutional and outpatient settings were assigned to either reality-adaptive, supportive psychotherapy or exploratory, insight-oriented psychotherapy.

Those included in the analysis (95 of the original 164 patients) remained in their assigned treatment situation for at least 6 months. At 2-year follow-up, the investigators obtained complete data on 47 of the original sample. At this point in the data analysis, patients receiving reality-adaptive, supportive therapy showed less recidivism and better role performance. On the other hand, patients who received exploratory, insight-oriented therapy had greater improvements in cognition and ego functioning. The investigators concluded that overall differences between the two groups were relatively minor.

Unfortunately, despite the sophisticated methodology and design of the Boston study, generalizability of the results must be limited for several reasons. First, only 47 patients completed the 2-year course of the project; thus, many of the definitive comparisons were based on approximately 20 subjects in each treatment group (Carpenter 1984). Second, the data collection stopped after 2 years. Many experienced therapists of schizophrenic patients would consider 2 years to be merely the beginning of the middle phase of therapy. Patients with schizophrenia are notoriously difficult to engage in a psychotherapeutic process. Moreover, expecting a therapist to adhere to either a more-or-less expressive or a more-or-less supportive model in the treatment of a schizophrenic patient introduces an artificiality into the treatment being evaluated. Nowhere is flexibility more important than in the psychotherapy of schizophrenia. As stressed in Chapter 4, in a naturalistic setting the psychotherapist will shift back and forth from expressive to supportive interventions depending on the needs of the patient at a given moment.

The investigators themselves (Glass et al. 1989) subsequently blindly rated the actual process of therapy from audiotaped transcripts and concluded that the earlier finding of little overall differences between the two groups "concealed discrete processes within the therapies that have important and specific effects" (p. 607). Therapists who were rated as skilled in dynamic exploration produced greater improvements in global psychopathology, denial of illness, and retardation–apathy.

Finally, one other irreducible difference between the needs of research and the ambience of clinical practice should be taken into account in interpreting the Boston study data. The motivations, both conscious and unconscious, that lead a psychotherapist to enter into what could become a lifelong commitment to treating a schizophrenic patient are both mysterious and highly personal. Whatever forces lead a therapist and patient to "choose" each other are ignored by large-group designs that require scientifically rigorous random assignment of patient to therapist (Müller 1984). Only intensive study of individual cases can shed light on this significant contributor to psychotherapeutic success.

In a subsequent report, Gunderson (1987) acknowledged the difficulty of engaging schizophrenic patients in a long-term psychotherapy process. He noted that his study and others have suggested that about two-thirds of schizophrenic patients will drop out of psychotherapy when assigned nonspecifically as part of a research study. Gunderson carefully examined the data from the Boston study to determine the typical characteristics of those who continued in psychotherapy. His surprising finding was that they were characterized by social isolation, emotional flatness, and internal disorganization. However, they tended to have more consistent role performance than the dropout group. He also determined that dropout rate is affected by cultural norms within the hospital milieu. For example, patients from the Veterans Administration hospital used in the study were much more likely to drop out than those hospitalized at McLean Hospital, where psychotherapy is a standard part of treatment. Gunderson also concluded that longer-term hospitalization may be helpful in engaging patients. When he divided the patients according to whether they received reality-adaptive, supportive psychotherapy or exploratory, insight-oriented psychotherapy, he determined that emotionally distant, thought-disordered patients with an optimistic view of their illness were most likely to continue with the former modality, whereas patients who had fairly intact reality testing, reasonably good interpersonal relatedness, and a view of their psychotic episode as an unfortunate event were more likely to continue with the latter treatment.

Gunderson's findings are consistent with those of McGlashan's (1984, 1987) long-term follow-up study of patients treated at Chestnut Lodge. In this study, 163 schizophrenic patients previously hospitalized at Chestnut Lodge while receiving intensive psychoanalytically oriented psychotherapy were followed up an average of 15 years after discharge. About one-third of these patients had moderate-to-good outcomes (McGlashan 1984). Of the two identifiable groups whose psychosis remitted, one group attempted to integrate the psychotic experience into their life. They believed that they had gained important information from the psychotic episode, and they were curious about the meaning of their symptoms. The second group showed another pathway to stable recovery, namely, that of "sealing over" the illness. These patients tended to have a fixed, negative view of their illness and no interest in understanding their psychotic symptoms. Although both groups had achieved reasonably stable adjustments, those who integrated their experiences appear to have had somewhat superior outcomes.

These findings suggest that patients who can integrate a psychotic experience into their lives may benefit from exploratory work in the context of psychotherapy, whereas those who seal over a psychotic episode will probably not benefit and may perhaps even be harmed by persistent exploratory attempts. Even psychotherapies that involve some insight will require signif-

icant support by the therapist. The expressive-supportive distinction is certainly less rigid in the psychotherapy of schizophrenia than in the treatment of higher-functioning patients.

In fact, many would argue that supportive approaches are essential for success with patients who have schizophrenia. A prospective longitudinal Danish study of 269 consecutively admitted patients (Rosenbaum et al. 2012) compared manualized supportive psychodynamic psychotherapy in addition to treatment as usual with treatment as usual alone for patients with a first-episode schizophrenia spectrum disorder. Although randomization was not part of the study, the investigators made a major effort to minimize bias. After 2 years, symptomatic improvement and global functioning were significantly superior in the group with supportive dynamic psychotherapy and treatment as usual compared with treatment as usual alone.

Personal therapy (Hogarty et al. 1995, 1997a, 1997b) is one of the most rigorously tested of the individual psychosocial interventions with schizophrenia. In contrast to psychodynamic therapies, which are generally not specific to a disorder, personal therapy is disorder specific. It is also grounded in research on the illness; hence, it is based on the stress-vulnerability model and considers stress-related affect dysregulation as central to symptom exacerbation. Some psychodynamic therapists have based their assumptions about the illness on psychoanalytic theories that may have no empirical basis. On the other hand, a range of therapeutic techniques characterize personal therapy, and many dynamic therapists are similarly flexible in adjusting their approach to the patient's needs.

Personal therapy proceeds in phases. In the initial phase, the focus is on clinical stabilization of symptoms, development of the therapeutic alliance, and provision of basic psychoeducation. This phase usually occurs during the first few months after discharge from the hospital. The intermediate phase is geared toward helping the patient become aware of internal affective cues associated with stressors. Some patients might also at this point begin social skills training, exercises in relaxation, and training to enhance social perception. The advanced phase of the therapy is designed to provide opportunities for introspection. In addition, the patient receives instruction in principles of conflict resolution and criticism management. In each phase, the therapy is tailored to the patient's individual needs.

Hogarty et al. (1997a, 1997b) randomly assigned 151 patients with schizophrenia to personal therapy or to one of two comparison treatments: family therapy or supportive individual therapy. They followed the patients for 3 years after hospital discharge. Only 18% prematurely terminated the study, and of those, most were not in the personal therapy group. Personal therapy was found to be more effective than family and supportive therapies in preventing psychotic and affective relapse as well as medication noncom-

pliance; however, this greater effectiveness was seen only in those patients living with their families. Among patients who did not live with their families, those who received personal therapy did worse—they had significantly more psychotic decompensations than did those receiving supportive therapy. The investigators concluded that personal therapy should probably be delayed until patients have achieved residential stability and symptomatic improvement.

In this study, personal therapy appeared to be highly beneficial for role performance or social adjustment, but its effects on symptoms were not significantly greater than those of the comparison treatments. In fact, patients who received personal therapy actually had *more* anxiety than those who received supportive therapy or family treatment. Also, personal therapy seemed to be more durable in its impact than supportive therapy. Patients who received personal therapy continued to improve in social adjustment during the second and third years after discharge, whereas those receiving supportive therapy, with or without family intervention, experienced adjustment effects that peaked at 12 months after discharge and then plateaued.

In keeping with our contemporary understanding of the optimal treatment strategy for schizophrenia, personal therapy was only one modality in the overall treatment plan in Hogarty et al.'s study. Patients received antipsychotic medications, and various rehabilitation approaches were also used in conjunction with the personal therapy. As Fenton and McGlashan (1997) note, personal therapy provides the ideal context in which to consider "the specific combination of interventions that will be most helpful for this particular patient with this particular type of schizophrenia at this particular phase of illness or recovery" (p. 1495). This effort to tailor the choice of interventions to the patient's specific needs makes good clinical sense. Personal therapy can certainly be applied within a framework of psychodynamic understanding of the patient's defenses, object relations, and sense of self.

In addition, randomized controlled trials of cognitive-behavioral therapy (CBT) have shown that psychotherapeutic interventions can be a useful component of an overall treatment plan for schizophrenia (Kuipers et al. 1998; Tarrier et al. 1998). In one study, patient improvements resulting from cognitive-behavioral therapy were largely sustained at 18-month follow-up (Kuipers et al. 1998). Strategies such as training in problem solving and relapse prevention appeared to be particularly useful in this study and should be incorporated in any psychotherapeutic approach. A summary of all the current research on CBT suggested that this psychotherapy decreases the severity of delusions, hallucinations, positive symptoms, and negative symptoms and improves social functioning (Dixon et al. 2010). However, most patients who have had recent-onset schizophrenia and those in the midst of an acute exacerbation of psychotic symptoms have not been well studied with CBT.

In a randomized controlled trial of cognitive therapy with patients who had negative symptoms and were extremely disabled, Grant et al. (2012) found that even persistent negative symptoms in this population could be improved using a cognitive model that implicates fear of failure and corresponding behaviors aimed at preventing it. The approach used normalizing explanations to improve the therapeutic alliance and reduce stigma. Socratic questioning was also employed as a way of developing alternative explanations of psychotic phenomena. Collaborative formulations are developed, such as helping a patient recognize that the way the patient feels about the voices, not the voices themselves, is the source of anger.

In their overview of psychosocial treatments for schizophrenia, Keshavan and Eacke (2014) emphasized that the role of a continuous and positive therapeutic alliance is a powerful predictor of therapeutic outcome. However, few tasks are more challenging than building a therapeutic alliance with someone who suffers from schizophrenia because of the patient's frequent lack of insight into his or her illness.

Selzer and Carsky (1990) stressed the importance of finding an organizing object—a person, an idea, or an inanimate object—that allows the patient and the therapist to talk about what is going on between them. In this early stage of treatment, patients are often unable to acknowledge that they are ill and in need of treatment, and the main focus must be establishing relatedness. For example, Frese (1997) cautioned clinicians to avoid challenging patients' delusional beliefs. He pointed out that when patients have delusions, they naturally assume them to be true, even in the face of evidence to the contrary. Frese, who himself had schizophrenia for many years while pursuing a successful career as a psychologist, advised clinicians to think of patients as speaking poetically and metaphorically. He suggested that it is useful to help patients see how others regard their beliefs, so that patients can avoid certain actions that may cause them to be admitted to a psychiatric hospital. By allying with the patient's need to avoid hospitalization, the therapist may gain the patient's cooperation and compliance with other aspects of the treatment plan, such as medication.

Much of the early work of psychotherapy must be directive and designed to repair deficits of the patient that impede development of a therapeutic alliance (Selzer 1983; Selzer and Carsky 1990; Selzer et al. 1989). The ensuing work on building an alliance may have significant payoffs. When Frank and Gunderson (1990) examined the role of the therapeutic alliance in the courses and outcomes of the 143 schizophrenic patients in the Boston Psychotherapy Study, they discovered that it was a key predictor of treatment success. Patients with good therapeutic alliances were more likely to remain in psychotherapy, more likely to comply with prescribed medication, and more likely to achieve good outcomes at the end of 2 years.

The treatment alliance can also be facilitated by supporting and restoring the patient's defenses, focusing on the patient's strengths, and providing a safe haven for the patient. McGlashan and Keats (1989) emphasized that above all, psychotherapy should offer asylum. Feelings and thoughts that others do not understand are accepted by the psychotherapist. Withdrawal or bizarre behavior is accepted and understood without any demand that the patient change to be acceptable. Much of this aspect of technique consists of "being with" (McGlashan and Keats 1989)—a willingness to consistently put oneself in the company of another human being without making inordinate demands. As Karon (1992) pointed out, terror is the primary affect in the person with schizophrenia. Therapists must be able to accept feelings of terror when they are projected onto them and avoid withdrawing and being overwhelmed in the face of such powerful affects.

As the alliance becomes solidified, the therapist can then begin to identify individual-specific relapse factors and help the patient to accept the fact that he or she has a serious illness. The therapist must also serve as an auxiliary ego for the patient. When profound ego weaknesses, such as poor judgment, are in evidence, the therapist may help the patient to anticipate the consequences of his or her actions.

In conducting psychotherapy with persons with schizophrenia, the therapist will find Bion's (1967) distinction between the psychotic and nonpsychotic parts of the personality a useful tool. The psychotic part of the patient's mind attacks the reality-based, rational thinking of the nonpsychotic part. Painful feelings are also projected onto others because the psychotic part of the patient cannot bear the frustration, so the therapist must look for clues in the countertransference feelings evoked by the patient (Lucas 2003). Moreover, no matter how psychotic the patient may be, there is always a nonpsychotic sector that the therapist can address.

The therapist must be attuned to deficits. Some patients will have substantial neurocognitive limitations that the therapist may tactfully point out. When these deficits are addressed, the therapist may also wish to provide advice on how to compensate for the deficits so that the patient does not feel hopeless about them.

Some excellent work based on cognitive-behavioral therapy, with empirical research demonstrating its efficacy, has been described in detail by Kingdon and Turkington (1994). Much of their approach is closely related to dynamically informed supportive therapy, which recognizes fragility and seeks to strengthen ego functioning. For example, in discussing a patient's hallucinations, the therapist may wish to explore the idiosyncratic quality of the perception. Questions such as "Can anybody else hear what is said?" may be asked, and the therapist might inquire about the patient's beliefs regarding the origin of the voices. In working with delusions, the therapist

may tactfully ask if there are other possible explanations for the phenomena the patient believes. Is it possible that the patient is taking things personally or reading things into behaviors of others? It is also worth exploring an inference chain. For example, if the patient believes that a silicon chip is in his brain, the therapist might want to know how electricity would get to the chip. The patient's experience should generally be accepted, and a positive atmosphere should be created for exploration that may lead to some critical thinking by the patient about other possibilities.

Only after a solid alliance is established, individual-specific relapse factors have been noted and discussed, deficits have been addressed, and the patient is well established in a residential situation with family or others should the therapist attempt an expressive approach in which insight or interpretation is central. Some patients may never reach that point. When supportive and rehabilitative strategies are sufficient, the therapist may wish to leave well enough alone. The fantasy of rescuing the patient from schizophrenia must be avoided—it is the worst possible psychological attitude for a therapist. Therapists must be comfortable with the possibility that patients will choose "the devil they know" in preference to facing the uncertainties of change and improvement. Effective psychotherapy requires an attitude in the therapist that allows the patient's wish to remain ill to be an acceptable alternative to psychotherapeutic change (Searles 1976/1979). Nonetheless, a substantial subgroup of persons with schizophrenia will want to collaborate with a therapist to gain an understanding of their illness and how it has shattered their sense of who they are. In the professional literature, schizophrenic patients have spoken eloquently about the benefits of individual psychotherapy (Anonymous 1986; Ruocchio 1989). These patients comment on the importance of having one consistent figure in their lives who is there through any adversity over many years. These patients convey how their subjective experiences of themselves and of their lives were significantly altered by a long-term psychotherapeutic relationship, even though outcome measures may not be sensitive enough to record such alterations. In the words of one patient (Anonymous 1986), "A fragile ego left alone remains fragile. Medication or superficial support alone is not a substitute for the feeling that one is understood by another human being" (p. 70).

One of the most articulate voices has been that of Elyn Saks (2008, 2009). She is a law professor who credits psychoanalysis with saving her life. She has written eloquently about the value of medication and the importance of overcoming denial of one's illness. She said that the therapeutic relationship is at the heart of everything because it helped her overcome the isolation of schizophrenia and provided someone who can help her determine what is real and what is not. She stressed that narcissistic injury fuels most denial, which she regards as self-protective in the phase of catastrophic

illness that redefines the person. Only the ongoing help of psychotherapeutic intervention and her repeated observation that symptoms return whenever she stops medication finally convinced her to overcome denial.

Group Psychotherapy

Studies of group psychotherapy with schizophrenic patients suggest that this modality may be useful, but they emphasize the timing of its implementation. The optimal time appears to be after positive symptoms are stabilized through pharmacological intervention (Kanas et al. 1980; Keith and Matthews 1984). The acutely disorganized patient is unable to screen out environmental stimuli, and the multiple inputs from a group setting may overwhelm the patient's already beleaguered ego just when it is attempting to reestablish itself. One review of controlled studies of group therapy for schizophrenia (Kanas 1986) found considerable evidence for the efficacy of inpatient group psychotherapy but a clear trend for greater success on long-term chronic units than on acute wards. After positive symptomatology is controlled, inpatient groups can be highly supportive for schizophrenic patients as they are reorganizing and as they see others preparing for discharge. Efficacy studies suggest that, as an outpatient modality, group therapy may be as effective as individual therapy (O'Brien 1983). For the patient who is stabilized on medication, weekly sessions of 60–90 minutes can serve to build trust and can provide a support group where patients can freely discuss concerns such as how to manage auditory hallucinations and how to deal with the stigma of mental illness.

Family Intervention

In the empirical research literature on the efficacy of psychosocial interventions with schizophrenia, no modality has been more substantiated than family interventions. Numerous studies (Falloon et al. 1982; Goldstein et al. 1978; Hogarty 1984; Leff et al. 1982) have demonstrated that family treatment plus antipsychotic medication is three times as effective as medication alone in preventing relapse. These investigations used a factor known as expressed emotion (EE), first identified by Brown et al. (1972). This term was coined to describe a style of interaction between family members and the patient that is characterized by intense overinvolvement and excessive criticism. Although this concept does not blame parents for causing schizophrenia in their children, it does acknowledge that families are affected by schizophrenia and that they may become secondary contributors to relapse through an intensification of their interactions with the schizophrenic patient. In brief, high-EE families produce a greater frequency of relapse in a schizophrenic member than do low-EE families.

A meta-analysis of 27 studies of the EE-outcome relationship with schizophrenia confirmed that EE is a significant and robust predictor of relapse (Butzlaff and Hooley 1998). The relationship between high EE and relapse appeared to be strongest for patients with more chronic forms of schizophrenia. Recent research suggests there is a specific synergy between neurocognitive vulnerabilities and family criticism. Rosenfarb et al. (2000) demonstrated that in 41 patients with recent-onset schizophrenia, the combination of working memory deficits and criticism from family members jointly predicted psychotic thinking.

The extensive research on EE has led to development of a sophisticated psychoeducational approach with families of schizophrenic persons. The families are trained to recognize prodromal signs and symptoms that presage relapse, are taught to reduce criticism and overinvolvement, and are helped to see that a consistent medication program can preserve optimal functioning. Other areas of education include instruction about the side effects of medications and their management, the long-term course and prognosis of schizophrenia, and the genetic and biological basis of schizophrenia. Clinicians using this approach can effectively enlist the family's help as collaborators in the prevention of relapse.

The rigor of the research on family interventions with persons who have schizophrenia is admirable. Studies generally use randomization, well-established inclusion criteria, systematically collected outcomes, evidence of adherence to the intervention, and suitable controls. Reviews of the efficacy of these family treatments suggest that long-term family intervention is effective for lowering relapse rate, reducing EE, and improving outcome (Dixon and Lehman 1995; Penn and Mueser 1996). The treatment gains appear to be fairly stable as well, often enduring for as long as 2 years. The family approach to schizophrenia based on high EE is also an extremely cost effective approach when one considers the cost to society of severe mental illness. McFarlane (2002) even found this approach quite effective with multifamily groups. In this way it becomes more affordable to those with limited means.

The impressive results obtained with this conceptual model of family intervention have been challenged, however. Some investigators have questioned whether controlling EE is the exclusive factor involved in relapse prevention. One study (MacMillan et al. 1986) found that the regular ingestion of antipsychotic medication and the preadmission duration of illness were factors that, when taken into account, canceled out the effect of EE in predicting relapse. Another study (Parker et al. 1988) examined 57 schizophrenic patients from the standpoint of the EE level of the household. Relapse was predicted by a one-parent household and by a poor course of prior illness, but the level of EE was not predictive. The investigators speculated that those patients with a poor course may evoke responses in relatives that

are high in EE, particularly if the patient lives in a one-parent household. Falloon (1988) pointed out that the research on EE has not included serial measures of EE that would help determine whether behavior disturbances in schizophrenic patients *provoke* high-EE responses in parents or *result from* the stress of high-EE relatedness.

Additional questions have been raised about the high-EE construct and the family interventions that it informs. Many families of schizophrenic patients feel that they are being blamed for relapse when they are merely responding to a difficult situation in the best way they can (Lefley 1992). As Kanter et al. (1987) noted, if families are strongly urged to remain nonintrusive, they may fail to respond appropriately when provocative behavior and lack of control are exhibited by the schizophrenic family member. Moreover, in some cases it may be assumed that a switch from high to low EE has caused patient improvement when in fact the family has simply lowered its EE as a *result* of the improvement in the patient (Hogarty et al. 1986). Researchers also question whether EE is a construct that is stable over time (Lefley 1992). Other concerns include the observation that high EE is related to other illnesses besides schizophrenia, the fact that only a certain proportion of people with schizophrenia are influenced at all by high EE, and the realization that the entire construct is essentially cultural (Jenkins and Karno 1992).

Given the controversy surrounding the relationship between relapse and EE, clinicians may be puzzled about the most useful interventions to make with families. Kanter et al. (1987) stressed that psychoeducational efforts involving information about the illness, support, and advice may produce results that are just as impressive as the data from the EE studies. Hatfield (1990) stressed that education is probably more helpful than treatment in working with families and that specific interventions are not necessary. Nevertheless, because highly stimulating environments tend to be difficult for schizophrenic patients to deal with, there is sound wisdom in reducing the intensity of environmental stimuli. Moreover, recent research suggests that the two elements of EE—namely, emotional overinvolvement and excessive criticism—should not be lumped together (King and Dixon 1996). In this investigation of 69 patients and 108 relatives, emotional overinvolvement appeared to be associated with a *better* social outcome in patients, suggesting that excessive criticism may be the factor that promotes relapse.

Psychosocial Skills Training

Psychosocial rehabilitation, which is usually defined as a therapeutic approach that encourages patients to develop their fullest capacities through environmental supports and learning procedures (Bachrach 1992), should

be a major part of contemporary treatment for any person with schizophrenia. This individually tailored approach involves capitalizing on the patient's strengths and competencies, restoring hope to the patient, maximizing the patient's vocational potential, encouraging the patient's active involvement in his or her own treatment, and helping the patient develop social skills. These assorted goals are often subsumed under the heading of psychosocial skills training. Hogarty et al. (1991) found that recipients of psychosocial skills training made substantial improvements in social adjustment measures and had a lower rate of relapse at 1-year follow-up compared with a control group. However, this gain eroded within 2 years after the treatment.

Cognitive rehabilitation or remediation has also been incorporated into these strategies. Through repeated practice of related techniques, various cognitive deficits are modified. Reviews using meta-analytic techniques have demonstrated that cognitive remediation interventions can improve cognitive functioning in schizophrenia while also providing more generalizable benefits to problematic symptoms and other domains of functioning (Keshavan and Eack 2014). In social skills training, patients participate in role playing and other exercises to improve their functioning in interpersonal settings. The research on these approaches is not yet compelling regarding efficacy. Although there seem to be clear improvements in specific motor performance behaviors when training takes place, these skills may erode over time. Also, evidence for the generalizability of psychosocial skills training from the clinical setting to everyday life is rather weak (Keshavan and Eack 2004; Penn and Mueser 1996; Scott and Dixon 1995). Nevertheless, there is a general view that teaching specific skills and modifying cognitive deficits show promise as part of an overall treatment plan.

Hospital Treatment

For the schizophrenic patient who has an acute psychotic break, brief hospitalization provides "time out"—a chance to regroup and gain new direction for the future. Antipsychotic medication relieves most of the positive symptoms. The structure of the hospital unit provides a safe haven to prevent patients from hurting themselves or others. Nursing staff members in the milieu perform auxiliary ego functions for the patient. A psychoeducational effort can begin with the patient and family to establish an optimal posthospital environment. They should be prepared for the fact that they are dealing with a lifelong disease and that the goal is to minimize disability, not effect a lasting cure. The importance of staying on medication is emphasized, and the concept of EE may be explained as well. At the same time, the treatment team needs to convey a sense of hope. It is often useful to point out that although the disease is chronic, considerable research suggests that

some schizophrenic patients become more and more functional as they age (Harding et al. 1987).

The thrust of brief hospitalization is counterregressive. Defenses are restored, and the patient should be returned to functioning as expeditiously as possible. The patient's omnipotence is challenged by the necessity of accommodating to the needs of others. By enforcing a routine schedule in patients' lives, some frustration of their needs and wishes is unavoidable. This optimal level of frustration helps patients improve reality testing and other ego functions (Selzer 1983). After the patient's positive symptomatology is relieved to some extent, group treatment may be instituted and may also be continued on an outpatient basis, depending on the patient's amenability to the group format. For some isolated outpatients, group meetings may be their only significant social contact.

For those patients with predominantly negative symptoms, diagnosis and medication can be reassessed. Are there secondary reasons, such as depression, anxiety, and medication side effects, that might account for the negative symptoms? Similarly, the psychotherapy process, if ongoing, can be reevaluated with the collaboration of the therapist to determine whether to make a shift in strategy. Family work can proceed in a psychoeducational fashion, and family members can be enlisted in the search for ongoing stressors that prevent the patient from responding to conventional treatment.

Schizophrenic patients who are treatment resistant may also display a predominant picture of disordered interpersonal relatedness. These patients frequently have serious characterological difficulties that coexist with schizophrenia. Clinicians are sometimes prone to forget that every schizophrenic patient also has a personality. These characterological problems may therefore result in noncompliance with medication, alienation of family members and other supportive persons in the environment, denial of illness, and inability to function in a vocational setting. An inpatient unit or day hospital may be the ideal setting in which to address the characterological dimension accompanying the schizophrenia and to examine the underpinnings of the patient's noncompliance.

Many of the treatment principles described in this chapter are illustrated in the following detailed case example:

> Mr. I, a 22-year-old single man from the southeastern United States, had a 3-year history of schizophrenia that had not responded either to outpatient treatment with medication or to brief hospitalization. Referred for psychiatric hospitalization, he came for admission accompanied by his parents. When asked to describe his problems, he recited a litany of physical complaints involving virtually every anatomical area of his body but steadfastly denied any psychiatric problems. When he learned that he was being admitted to a psychiatric facility, he was reluctant to sign himself into the hospital.

Only with repeated reassurances that a complete physical and neurological workup was part of the psychiatric evaluation would he consent to hospitalization.

The patient's somatic preoccupations precluded any history taking of his psychiatric disorder. Fortunately, his parents were able to fill in the gaps. Mr. I was the third of three children born to highly successful parents. The patient's father was a respected business executive, and his mother had a prominent administrative position in the school system. His older brother was a graduate of a prestigious medical school, and his older sister was an honors graduate student in her business administration program. The patient himself had briefly attended college but was forced to drop out after the onset of his illness. He complained of hypersensitivity to noise in his dormitory, and he expressed concern that others were talking about him. He finally demanded to be taken home so that he would not be humiliated by the other young men in the dormitory, whom he claimed were calling him "loser," "fag," and "crazy" in the middle of the night.

After leaving college, Mr. I returned to live with his parents, where he became increasingly demanding of their time. When his father attempted to leave for work in the morning, the patient would run out the door after him and sometimes jump on the hood of his car to prevent him from leaving. He would also wake his father in the middle of the night to demand that he listen to a recital of his physical complaints. He repeatedly accused his father of neglect by saying, "What are you going to do about my pain?" Mr. I had been seen by numerous specialists, and often several specialists in one field, without any diagnosis of physical disease. He insisted that he needed continual "monitoring" from his parents so that they would be aware of the waxing and waning of his physical symptoms. Mr. I was blessed with loving and concerned parents who attempted to accommodate his pleas for attention by spending long periods with him. On one occasion, the patient's father sat and listened to the patient's somatic preoccupations for 10 hours without a break.

Mr. I also continued to hear voices condemning him, and in one instance he assaulted a stranger on the street because he was convinced that the stranger was saying unpleasant things about him. Mr. I had been hospitalized for a few weeks each on two different occasions and had been prescribed four different antipsychotic medications at various times. Each time, the patient discontinued the medication because of his denial that he had a psychiatric condition that warranted psychotropic medication and because of anticholinergic side effects that bothered him.

Shortly after admission, a mental status examination revealed that the patient continued to suffer from auditory hallucinations, although he did not complain of "hearing voices." Rather, he was convinced that people were actually talking about him. On several occasions during the first few days of his hospitalization, he angrily confronted other patients because he thought that they were ridiculing him. All of them vehemently denied talking about him. In addition, Mr. I found it difficult to complete a thought because of a formal thought disorder that consisted of blocking and derailment. He would stop in midsentence, change the subject, then begin another sentence.

Mr. I displayed much anxiety in the hospital because none of the staff members would "monitor" his physical symptoms as his parents had. As ex-

pected, the patient attempted to re-create his family situation in the milieu. He developed intense transference attachments to his doctor and his primary nurse, whom he expected to be with him at all times. When his doctor left the unit after a meeting with him, Mr. I attempted to run out the door after him just as he had tried to stop his father from going to work.

Physical and neurological examinations revealed no significant findings. After a careful psychiatric evaluation, the treatment team developed an explanatory formulation. The patient's paranoid concerns and somatic preoccupations masked an extraordinarily low sense of self-esteem. Mr. I had grown up feeling like the "black sheep" of the family because his limitations had precluded competition with the high achievers surrounding him. To preserve some degree of self-esteem, he formed an identity as a "victim" of disabling physical problems that kept him from performing at an acceptable level. Mr. I was then able to attribute his failures in school and in various jobs to physical illnesses.

The somatic concerns also provided an organizing focus for the patient's thoughts, thereby preventing a more profound state of psychotic fragmentation or self-dissolution. This severe somatic preoccupation was linked to his paranoid perception of ridicule from others through the mechanisms of introjection and projection. Early in life, Mr. I had internalized (as persecuting objects) the expectations and demands of his parents. Thus, strangers on the street or in the hallway who were perceived as talking about him had become these persecuting objects that he had projected onto the environment. When the persecutors were reintrojected, they became internal persecutors in the form of various aches and pains requiring immediate attention. Hence, the patient felt constantly under siege by a host of tormentors, both in his environment and within his body.

On a neurophysiological level, Mr. I's inability to screen out various stimuli may have compounded his feeling of numerous sources of pain and torment. Finally, the somatizing performed yet another function: it was the only way the patient knew to maintain object relatedness and therefore defend against severe separation anxiety. This patient clearly had little interest in any diagnostic evaluations or treatment suggestions from consultants. Such findings and recommendations were far less significant to him than his concern that he needed to be continuously "monitored." The patient's litany of physical complaints was not truly designed to elicit an ameliorating response from those around him; rather, its purpose was to maintain a continual external presence so that he would not have to face his anxieties about abandonment. Paradoxically, his barrage of complaints tended to evoke the opposite response, namely, to alienate and drive away others. Initially, the treatment team attempted to control Mr. I's positive symptoms through medication. However, the patient adamantly refused the medication because he associated it with previous doctors who had told him that his pain was "all in your head."

Respecting Mr. I's need to preserve self-esteem and organize his thinking through intense investment in physical symptoms, his hospital doctor assured him that no one was questioning the severity of Mr. I's pain. The doctor explained that the patient's illness had both psychological and physical aspects. The doctor further explained that one physical manifestation of the ill-

ness was difficulty filtering out various stimuli in the environment and within the body. Through this educational approach, Mr. I's doctor thus convinced the patient that the antipsychotic medication might be worth a trial because it often had a beneficial effect on the "filtering" system. After the patient agreed to take the medication, his thought disorder greatly improved, allowing him to talk more coherently with staff members and other patients. His auditory hallucinations continued despite the medication but abated somewhat in frequency and severity.

The treatment team then attempted to repair some of the patient's ego deficits by functioning as auxiliary egos. On one occasion, for example, a nurse was meeting with Mr. I in a closed room on the hospital unit when he began to claim that people were talking about him outside in the hallway. To demonstrate that no one was there, the nurse opened the door and walked with Mr. I into the hallway. She then explained to the patient that his illness involved voices that originated on the inside, which were then perceived as though coming from outside sources. This approach was reinforced by feedback from fellow patients in group meetings.

This patient had initially been held out of group meetings on the unit because of the overstimulating nature of that treatment modality. After being stabilized on medication, however, Mr. I began to attend the groups and frequently brought up his concern that others were talking about him. The other patients steadfastly denied these accusations, and they all encouraged him to "check it out" whenever he heard the voice. The patient's hostile accusations toward other patients and toward staff members gradually shifted to gentle inquiries as he realized that the voices did indeed emanate from within.

As Mr. I gained greater control over his positive symptoms, the treatment focus shifted to his disordered interpersonal relatedness. The patient attempted to establish the same relationship with his hospital doctor that he had with his father. The hospital doctor found himself spending more time in interaction with Mr. I than with any of his other patients. The urgency with which Mr. I presented his complaints of diarrhea, stomachaches, joint pain, and so on made his hospital doctor reluctant to disengage from Mr. I and leave the unit. One day when Mr. I frantically followed him out of the unit and continued to walk down the sidewalk with him, the doctor realized the extent to which the patient had replicated his family situation in the hospital. Mr. I felt as though he deserved the complete attention of his doctor and was oblivious to the needs of other patients who shared the same physician. The doctor then told Mr. I that he should lower his expectations of how much time the doctor would spend with him. This limit-setting approach addressed the patient's sense of entitlement.

This approach also presented a new form of object relatedness for the patient to internalize. The object relationship paradigm of a complaining, demanding self linked to an indulgent object was modified by Mr. I's experience of a new object that was caring but also limit setting. The experience with this new object correspondingly brought about changes in the patient's self representation. Although initially frustrated, the patient became more tolerant of the doctor's absences and more accepting of limitations on his expectations of others. Moreover, the limitations Mr. I encountered in this relationship led

him to discuss his separation anxiety with his doctor. Mr. I began to express concern that in the absence of a caretaking figure, his basic needs would go unmet.

The early phase of this psychotherapy was characterized by the patient's extensive reports about his physical symptoms. The patient's therapist listened to these reports with interest and concern, empathizing with his need to focus on the somatic rather than the psychological. Periodically, however, the therapist would comment that he was really unable to help the patient with any physical ailments because he had nothing to add to the extensive work of the treatment team and the consultants. As trust developed, the patient began to discuss his profound feelings of inferiority within his family context. Although his brother and sister had distinguished themselves academically, his only distinction was that he had a variety of bizarre ailments that prevented him from similar success. The patient's denial of psychiatric illness, his lack of psychological mindedness, and his lack of curiosity about his symptoms all led the therapist to take a predominantly supportive approach. Within that context, then, the patient was finally able to explore a surprisingly broad range of feelings about himself and his place in his family.

As part of the overall treatment plan, the patient became involved in a social skills group with a small number of his peers. In this setting, he received gentle confrontation about his hygiene problems, his failure to answer conversational questions, his self-absorption, and his obliviousness to the needs of others. He began to improve in all these areas in addition to generally improving his interpersonal functioning. For example, he began to say "good morning" to others who spoke to him, and he would even inquire as to their well-being. The patient also entered a vocational assessment and training program where he had to perform simple tasks under supervision. The activities therapist in charge of the program was careful to gear the level of complexity of the tasks to the patient's ability so that his self-esteem was not seriously threatened. Finally, a psychoeducational approach was employed with the patient's parents to help them accept their son's limitations. They were told that overinvolvement and excessive expectations would be counterproductive because the patient would experience them as pressure to succeed beyond his capacities.

This fragment of dynamically informed treatment illustrates how the different theoretical frameworks discussed in Chapter 2 may be useful in the treatment of one patient. Self psychological principles led the treatment team to an empathic awareness of this patient's need to maintain self-esteem, and his treaters therefore chose not to challenge his somatization. An object relations theoretical framework facilitated the doctor's understanding of this patient's problematic relationship with the doctor. Finally, the ego psychological perspective was helpful in two ways: 1) an ego-deficit model was applied in the form of the nursing staff's ego-building techniques, and 2) a conflict model was used to understand the auditory hallucinations. The persecutory voices this patient heard calling him a "loser" or "crazy" grew out of a painful conflict between the internalized expectations of his parents (in

the form of his ego ideal and superego) and the reality of his limitations (realistic ego functioning). These voices always seemed more evident after the patient experienced any failure in his vocational program. In today's climate of brief inpatient stays for stabilization only, this multidisciplinary and well-integrated approach to treatment is not often possible in a hospital setting. However, the principles can be adopted from this approach to various outpatient settings such that the whole person is treated from a dynamically informed perspective.

In summary, patients with schizophrenia need therapeutic figures in their lives. They need help navigating through the complicated realities of the mental health system. They also need someone to facilitate their understanding of the fears and fantasies that prevent them from accepting their illness and complying with the various components of their overall treatment plan. Indeed, a central role of the psychotherapist is to explore compliance problems that arise in other areas of treatment. In contemporary practice, this role is often assigned to a clinical case manager, usually because the patient is not interested in therapy or because community resources cannot provide psychotherapy. Case managers serve as patient advocates, guides to mental health resources, and coordinators of the total treatment plan. Even though case management is oriented to reality and to adaptation, transference and countertransference issues arise; case managers must thus be capable of providing effective psychotherapeutic interventions (Kanter 1989). What persons with schizophrenia most need are concerned individuals, whether called case managers or psychotherapists, who can offer compassionate human relationships for sanctuary from a confusing and threatening world.

References

Abdelmalik P, Husted J, Chow EWC, et al: Childhood head injury and expression of schizophrenia in multiply affected families. Arch Gen Psychiatry 60:231–236, 2003

Andreasen NC, Olsen SA, Dennert JW, et al: Ventricular enlargement in schizophrenia: relationship to positive and negative symptoms. Am J Psychiatry 139:297–302, 1982

Andreasen NC, Flaum M, Swayze VW, et al: Positive and negative symptoms in schizophrenia: a critical reappraisal. Arch Gen Psychiatry 47:615–621, 1990

Anonymous: Can we talk? The schizophrenic patient in psychotherapy: a recovering patient. Am J Psychiatry 143:68–70, 1986

Arlow JA, Brenner C: The psychopathology of the psychoses: a proposed revision. Int J Psychoanal 50:5–14, 1969

Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. Am J Psychiatry 149:1455–1463, 1992

Bion WR: Differentiation of the psychotic from non-psychotic personalities (1957), in Second Thoughts: Selected Papers on Psycho-Analysis. New York, Jason Aronson, 1967, pp 43–64

Blatt SJ, Wild CM: Schizophrenia: A Developmental Analysis. New York, Academic Press, 1976

Brown GW, Birley JLT, Wing JK: Influence of family life on the course of schizophrenic disorders: a replication. Br J Psychiatry 121:241–258, 1972

Buztlaff RL, Hooley JM: Expressed emotion and psychiatric relapse: a meta-analysis. Arch Gen Psychiatry 55:547–552, 1998

Cannon M, Caspi A, Moffit T et al: Evidence for early childhood, pan-developmental impairment specific to schizophreniform disorder. Arch Gen Psychiatry 59:449–456, 2002

Carpenter WT Jr: A perspective on the Psychotherapy of Schizophrenia Project. Schizophr Bull 10:599–602, 1984

Carpenter WT Jr, Henrichs DW, Wagman AMI: Deficit and nondeficit forms of schizophrenia: the concept. Am J Psychiatry 145:578–583, 1988

Conte HR, Plutchik R: Controlled research and supportive psychotherapy. Psychiatric Annals 16:530–533, 1986

Dixon LB, Lehman AF: Family interventions for schizophrenia. Schizophr Bull 21: 631–643, 1995

Dixon L, Dickerson F, Bellack AS, et al: The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. Schizophr Bull 36:48–70, 2010

Duckworth K, Nair V, Patel JK, et al: Lost time, found hope and sorrow: the search for self, connection, and purpose during "awakenings" on the new antipsychotics. Harv Rev Psychiatry 5:227–233, 1997

Falloon IRH: Expressed emotion: current status. Psychol Med 18:269–274, 1988

Falloon IRH, Boyd JL, McGill CW, et al: Family management in the prevention of exacerbations of schizophrenia: a controlled study. N Engl J Med 306:1437–1440, 1982

Federn P: Ego Psychology and the Psychoses. New York, Basic Books, 1952

Fenton WS, McGlashan TH: We can talk: individual psychotherapy for schizophrenia. Am J Psychiatry 154:1493–1495, 1997

Frank AF, Gunderson JG: The role of the therapeutic alliance in the treatment of schizophrenia: relationship to course and outcome. Arch Gen Psychiatry 47:228–236, 1990

Freedman R, Adler LE, Myles-Worsley M, et al: Inhibitory gating of an evoked response to repeated auditory stimuli in schizophrenic and normal subjects: human recordings, computer simulation, and an animal model. Arch Gen Psychiatry 53:1114–1121, 1996

Frese FJ: Recovery: myths, mountains, and miracles. Presentation to The Menninger Clinic staff, Topeka, KS, May 30, 1997

Freud S: Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides) (1911), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 1–82

Freud S: The loss of reality in neurosis and psychosis (1924a), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 19. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 181–187

Freud S: Neurosis and psychosis (1924b), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 19. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 147–153

Freud S: On narcissism: an introduction (1914), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 67–102

Freud S: The unconscious (1915), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 159–215

Fromm-Reichmann F: Principles of Intensive Psychotherapy. Chicago, IL, University of Chicago Press, 1950

Garfield D: Self-criticism in psychosis: enabling statements in psychotherapy. Dynamic Psychotherapy 3:129–137, 1985

Garfield D, Rogoff M, Steinberg S: Affect-recognition and self-esteem in schizophrenia. Psychopathology 20:225–233, 1987

Glass L, Katz H, Schnitzer R, et al: Psychotherapy of schizophrenia: an empirical investigation of the relationship of process to outcome. Am J Psychiatry 146:603–608, 1989

Goldstein MJ, Rodnick EH, Evans JR, et al: Drug and family in the aftercare of acute schizophrenics. Arch Gen Psychiatry 35:1169–1177, 1978

Grand S: The body and its boundaries: a psychoanalytic view of cognitive process disturbances in schizophrenia. International Review of Psychoanalysis 9:327–342, 1982

Grant PM, Huh GA, Perivoliotis D, et al: Randomized trial to evaluate the efficacy of cognitive therapy for low functioning patients with schizophrenia. Arch Gen Psychiatry 69:121–127, 2012

Grinspoon L, Ewalt JR, Shader RI: Schizophrenia: Pharmacotherapy and Psychotherapy. Baltimore, MD, Williams & Wilkins, 1972

Grotstein JS: The psychoanalytic concept of schizophrenia, I: the dilemma. Int J Psychoanal 58:403–425, 1977a

Grotstein JS: The psychoanalytic concept of schizophrenia, II: reconciliation. Int J Psychoanal 58:427–452, 1977b

Gunderson JG: Engagement of schizophrenic patients in psychotherapy, in Attachment and the Therapeutic Process: Essays in Honor of Otto Allen Will, Jr. Edited by Sacksteder JL, Schwartz DP, Akabane Y. Madison, CT, International Universities Press, 1987, pp 139–153

Gunderson JG, Frank AF, Katz HM, et al: Effects of psychotherapy in schizophrenia, II: comparative outcome of two forms of treatment. Schizophr Bull 10:564–598, 1984

Harding CM, Zubin J, Strauss JS: Chronicity in schizophrenia: fact, partial fact, or artifact? Hosp Community Psychiatry 38:477–486, 1987

Hatfield AB: Family Education in Mental Illness. New York, Guilford, 1990

Hogarty GE: Depot neuroleptics: the relevance of psychosocial factors—a United States perspective. J Clin Psychiatry 45:36–42, 1984

Hogarty GE, Anderson CM, Reiss DJ, et al: Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia, I: one-year effects of a controlled study on relapse and expressed emotion. Arch Gen Psychiatry 43:633–642, 1986

Hogarty GE, Anderson CM, Reiss DJ, et al: Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia, II: two-year effects of a controlled study on relapse and adjustment. Arch Gen Psychiatry 48:340–347, 1991

Hogarty GE, Kornblith SF, Greenwald D, et al: Personal therapy: a disorder-relevant psychotherapy for schizophrenia. Schizophr Bull 21:379–393, 1995

Hogarty GE, Kornblith SJ, Greenwald D, et al: Three-year trials of personal therapy among schizophrenic patients living with or independent of family, I: description of study and effects on relapse rates. Am J Psychiatry 154:1504–1513, 1997a

Hogarty GE, Greenwald D, Ulrich RF, et al: Three-year trials of personal therapy among schizophrenic patients living with or independent of family, II: effects on adjustment of patients. Am J Psychiatry 154:1514–1524, 1997b

Jenkins JH, Karno M: The meaning of expressed emotion: theoretical issues raised by cross-cultural research. Am J Psychiatry 149:9–21, 1992

Judd LL, McAdams LA, Budnick B, et al: Sensory gating deficits in schizophrenia: new results. Am J Psychiatry 149:488–493, 1992

Kanas N: Group therapy with schizophrenics: a review of controlled studies. Int J Group Psychother 36:339–351, 1986

Kanas N, Rogers M, Kreth E, et al: The effectiveness of group psychotherapy during the first three weeks of hospitalization: a controlled study. J Nerv Ment Dis 168: 487–492, 1980

Kanter J: Clinical case management: definition, principles, components. Hosp Community Psychiatry 40:361–368, 1989

Kanter J, Lamb HR, Loeper C: Expressed emotion in families: a critical review. Hosp Community Psychiatry 38:374–380, 1987

Karon BP: The fear of understanding schizophrenia. Psychoanalytic Psychology 9: 191–211, 1992

Karon BP, VandenBos G: Psychotherapy of Schizophrenia. New York, Jason Aronson, 1981

Keith SJ, Matthews SM: Schizophrenia: a review of psychosocial treatment strategies, in Psychotherapy Research: Where Are We and Where Should We Go? Edited by Williams JBW, Spitzer RL. New York, Guilford, 1984, pp 70–88

Kendler KS, Eaves LJ: Models for the joint effect of genotype and environment on liability to psychiatric illness. Am J Psychiatry 143:279–289, 1986

Keshavan S, Eack SM: Psychosocial treatments for chronic psychosis, in Gabbard's Treatments of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Kety SS: Genetic and environmental factors in the etiology of schizophrenia, in Psychopathology: The Evolving Science of Mental Disorder. Edited by Matthysse H, Levy DL, Kagan J, et al. New York, Cambridge University Press, 1996, pp 477–487

Khashan KS, Abel KM, McNamee R, et al: Higher risk of offspring schizophrenia following antenatal maternal exposure to severe adverse life events. Arch Gen Psychiatry 65:146–162, 2008

King S, Dixon MJ: The influence of expressed emotion, family dynamics, and symptom type on the social adjustment of schizophrenic young adults. Arch Gen Psychiatry 53:1098–1104, 1996

Kingdon DG, Turkington D: Cognitive-Behavioral Therapy of Schizophrenia. New York, Guilford, 1994

Kirkpatrick B, Buchanan RW, Ross DE, et al: A separate disease within the syndrome of schizophrenia. Arch Gen Psychiatry 58:165–171, 2001

Klein DF: Psychosocial treatment of schizophrenia, or psychosocial help for people with schizophrenia? Schizophr Bull 6:122–130, 1980

Kuipers E, Fowler D, Garety P, et al: London–East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis, III: follow-up and economic evaluation at 18 months. Br J Psychiatry 173:61–68, 1998

Leff J, Kuipers L, Berkowitz R, et al: A controlled trial of social intervention in the families of schizophrenic patients. Br J Psychiatry 141:121–134, 1982

Lefley HP: Expressed emotion: conceptual, clinical, and social policy issues. Hosp Community Psychiatry 43:591–598, 1992

Lieberman JA, Stroup TS, Perkins DO (eds): Essentials of Schizophrenia. Washington, DC, American Psychiatric Publishing, 2012

London NJ: An essay on psychoanalytic theory: two theories of schizophrenia, part I: review and critical assessment of the development of the two theories. Int J Psychoanal 54:169–178, 1973a

London NJ: An essay on psychoanalytic theory: two theories of schizophrenia, part II: discussion and restatement of the specific theory of schizophrenia. Int J Psychoanal 54:179–193, 1973b

Lucas R: The relationship between psychoanalysis and schizophrenia. Int J Psychoanal 84:3–15, 2003

MacMillan JF, Gold A, Crow TJ, et al: Expressed emotion and relapse. Br J Psychiatry 148:133–143, 1986

Mahler M: On child psychosis and schizophrenia: autistic and symbiotic infantile psychoses. Psychoanal Study Child 7:286–305, 1952

May PRA: Treatment of Schizophrenia: A Comparative Study of Five Treatment Methods. New York, Science House, 1968

McFarlane WR: Multifamily Groups in the Treatment of Severe Psychiatric Disorders. New York, Guilford, 2002

McGlashan TH: The Chestnut Lodge follow-up study, II: long-term outcome of schizophrenia and the affective disorders. Arch Gen Psychiatry 41:586–601, 1984

McGlashan TH: Recovery style from mental illness and long-term outcome. J Nerv Ment Dis 175:681–685, 1987

McGlashan TH, Keats CJ: Schizophrenia: Treatment Process and Outcome. Washington, DC, American Psychiatric Press, 1989

Müller C: Psychotherapy and schizophrenia: the end of the pioneers' period. Schizophr Bull 10:618–620, 1984

Munich RL, Carsky M, Appelbaum A: The role and structure of long-term hospitalization: chronic schizophrenia. Psychiatr Hosp 16:161–169, 1985

Myrin-Germeys I, van Os J, Schwartz JE: Emotional reactivity to daily life stress in psychosis. Arch Gen Psychiatry 58:1137–1144, 2001

O'Brien C: Group psychotherapy with schizophrenia and affective disorders, in Comprehensive Group Psychotherapy, 2nd Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1983, pp 242–249

Ogden TH: On the nature of schizophrenic conflict. Int J Psychoanal 61:513–533, 1980

Ogden TH: The schizophrenic state of nonexperience, in Technical Factors in the Treatment of the Severely Disturbed Patient. Edited by Giovacchini PL, Boyer LB. New York, Jason Aronson, 1982, pp 217–260

Olin SS, Mednick SA: Risk factors of psychosis: identifying vulnerable populations premorbidly. Schizophr Bull 22:223–240, 1996

Pao P-N: Notes on Freud's theory of schizophrenia. Int J Psychoanal 54:469–476, 1973

Parker G, Johnston P, Hayward L: Parental "expressed emotion" as a predictor of schizophrenic relapse. Arch Gen Psychiatry 45:806–813, 1988

Pedersen CB, Mortensen PB: Evidence of a dose-response relationship between urbanicity during upbringing and schizophrenia risk. Arch Gen Psychiatry 58:1039–1046, 2001

Penn DL, Mueser KT: Research update on the psychosocial treatment of schizophrenia. Am J Psychiatry 153:607–617, 1996

Plomin R, Defries JC, McClearn GE: Behavioral Genetics: A Primer, 2nd Edition. New York, WH Freeman, 1990

Robbins M: Psychoanalytic and biological approaches to mental illness: schizophrenia. J Am Psychoanal Assoc 40:425–454, 1992

Rogers CR, Gendlin ET, Kiesler DJ, et al (eds): The Therapeutic Relationship and Its Impact: A Study of Psychotherapy With Schizophrenics. Madison, University of Wisconsin Press, 1967

Rosenbaum B, Harder S, Knudsen P, et al: Supportive psychodynamic psychotherapy versus treatment as usual for first-episode psychosis: two-year outcome. Psychiatry 75:331–341, 2012

Rosenfarb IS, Nuechterlein KH, Goldstein MJ, et al: Neurocognitive vulnerability, interpersonal criticism, and the emergence of unusual thinking by schizophrenic patients during family transactions. Arch Gen Psychiatry 57:1174–1179, 2000

Rosenheck R, Tekell J, Peters J, et al: Does participation in psychosocial treatment augment the benefit of clozapine? Arch Gen Psychiatry 55:618–625, 1998

Rund BR: Fully recovered schizophrenics: a retrospective study of some premorbid and treatment factors. Psychiatry 53:127–139, 1990

Ruocchio PJ: How psychotherapy can help the schizophrenic patient. Hosp Community Psychiatry 40:188–190, 1989

Saks ER: The Center Cannot Hold: My Journey Through Madness. New York, Hyperion, 2008

Saks ER: Some thoughts on denial of mental illness. Am J Psychiatry 166:972–973, 2009

Scott JE, Dixon LB: Psychological interventions for schizophrenia. Schizophr Bull 21: 621– 630, 1995

Searles HF: Psychoanalytic therapy with schizophrenic patients in a private-practice context (1976), in Countertransference and Related Subjects: Selected Papers. New York, International Universities Press, 1979, pp 582–602

Selzer MA: Preparing the chronic schizophrenic for exploratory psychotherapy: the role of hospitalization. Psychiatry 46:303–311, 1983

Selzer MA, Carsky M: Treatment alliance and the chronic schizophrenic. Am J Psychother 44:506–515, 1990

Selzer MA, Sullivan TB, Carsky M, et al: Working With the Person With Schizophrenia: The Treatment Alliance. New York, New York University Press, 1989

Stanton AH, Gunderson JG, Knapp PH, et al: Effects of psychotherapy on schizophrenic patients, I: design and implementation of a controlled study. Schizophr Bull 10:520–563, 1984

Strauss JS, Carpenter WT, Bartko JJ: The diagnosis and understanding of schizophrenia, part III: speculations on the processes that underlie schizophrenic symptoms and signs. Schizophr Bull 11:61–69, 1974

Sullivan HS: Schizophrenia as a Human Process. New York, WW Norton, 1962

Tarrier N, Yusupoff L, Kinney C, et al: Randomised controlled trial of intensive cognitive-behaviour therapy for patients with chronic schizophrenia. BMJ 317:303–307, 1998

Tienari P, Wynne LC, Moring J, et al: The Finnish Adoptive Family Study of Schizophrenia: implications for family research. Br J Psychiatry 164(suppl 23):20–26, 1994

Tienari P, Wynne LC, Sorri A, et al: Genotype-environment interaction in schizophrenia-spectrum disorder: long-term follow-up study of Finnish adoptees. Br J Psychiatry 184:216–222, 2004

Wahlberg K-E, Lyman CW, Oja H, et al: Gene–environment interaction in vulnerability to schizophrenia: findings from the Finnish Adoptive Family Study of Schizophrenia. Am J Psychiatry 154:355–362, 1997

Wexler M: Schizophrenia: conflict and deficiency. Psychoanal Q 40:83–99, 1971

CHAPTER 8

AFFECTIVE DISORDERS

Psychodynamic approaches to understanding depression today recognize that affective disorders are strongly influenced by genetic and biological factors. In fact, depressive illness serves as an ideal model to study how genes and environment interact to produce clinical syndromes. We now understand the etiology of unipolar depression as approximately 40% genetic and 60% environmental (Nemeroff 2003).

Kendler and his colleagues (1993) followed 680 female–female twin pairs of known zygosity to determine whether an etiological model could be developed to predict major depressive episodes. They found that the role of genetic factors was substantial but not overwhelming. The most influential predictor was the presence of recent stressful events. Two other factors, interpersonal relations and a temperament characterized by neuroticism, also played a significant etiological role. Neuroticism appeared to alienate social support in many cases.

In a subsequent report from an expanded sample of the twin study, Kendler and his colleagues (1995) gained further insight into the etiology of depression. The most compelling model to emerge from their findings was one in which sensitivity to the depression-inducing effects of stressful life events appears to be under genetic control. For example, when the individuals at lowest genetic risk for major depression were examined, they had a probability of onset of major depression per month of only about 0.5% in the absence of a stressful life event. When these individuals were exposed to a stressor, however, the probability went up to 6.2%. In those individuals who were at the highest genetic risk, the probability of onset of depression per month was only 1.1% without exposure to a life stressor, but the risk rose dramatically, to 14.6%, when a stressful life event was present.

Further support for this model was provided by a prospective study of 1,037 children from New Zealand (Caspi et al. 2003). The investigators in this study found that a functional polymorphism in the promoter region of the serotonin transporter gene (*5-HTT*) was found to moderate the influence of stressful life events on depression. Other studies have replicated the Caspi group findings, and there is widespread speculation that those individuals with two s alleles in the 5-*HTTLPR* are more likely to become depressed in response to relatively common and low-threat events (Gotlib et al. 2008). In other words, this genetic polymorphism produces an increased sensitivity to the impact of stressful events. However, as noted in Chapter 1, some meta-analyses regarding this genetic polymorphism have produced negative results, and a countervailing view is that the impact of a broader network of genetic variations and environmental influences is necessary to come up with meaningful results (Blakely and Veenstra-VanderWeele 2011; Brzustowicz and Freedman 2011).

In a subsequent analysis, Kendler et al. (1999) found that about one-third of the association between stressful life events and onsets of depression was noncausal because those individuals predisposed to major depression select themselves into high-risk environments. For example, persons with a neuroticism temperament may alienate others and thus cause a breakup of a significant relationship. The most powerful stressors in the study appeared to be death of a close relative, assault, serious marital problems, and divorce/breakup. However, there is also considerable evidence that early experiences of abuse, neglect, or separation may create a neurobiological sensitivity that predisposes individuals to respond to stressors in adulthood by developing a major depressive episode. For example, Kendler et al. (1992) documented an increased risk for major depression in women who had experienced maternal or paternal separation in childhood or adolescence. In subsequent work, Kendler et al. (2001) found other gender differences regarding the depressogenic effect of stressful life events. Men were more sensitive to the depressogenic effects of divorce/separation and work problems, whereas women were more sensitive to the depressogenic effects of problems encountered with individuals in their proximal network.

As Nemeroff (1999) pointed out, Freud's view that early loss created a vulnerability that predisposed one to depression in adulthood has been confirmed by recent research. Agid et al. (1999) reported a case–control study in which rates of early parental loss due to parental death or permanent separation before the age of 17 years were evaluated in patients with various adult psychiatric disorders. Loss of a parent during childhood significantly increased the likelihood of developing major depression during adult life. The effect of loss due to permanent separation was more striking than loss due to death, as was loss before the age of 9 years compared with later child-

hood and adolescence. In addition, Gilman et al. (2003) found that parental divorce in early childhood was associated with a higher lifetime risk of depression. It is not only early childhood losses that appear to increase vulnerability to depression. Both physical and sexual abuse have been independently associated with adult depression in women (Bernet and Stein 1999; Bifulco et al. 1998; Brown 1993; Brown and Eales 1993). Women with a history of child abuse or neglect are twice as likely as those without such a history to have negative relationships and low self-esteem in adulthood (Bifulco et al. 1998). Those abused or neglected women who have these negative relationships and low self-esteem in adulthood are then 10 times more likely to experience depression.

The early trauma that appears to be relevant to a significant number of adults with depression can lead to permanent biological alterations. Vythilingam et al. (2002) found that depressed women with childhood abuse had an 18% smaller mean left hippocampal volume than nonabused depressed subjects and a 15% smaller mean left hippocampal volume than healthy subjects. In addition, a good deal of research has documented that levels of corticotropin-releasing factor (CRF), which induces the pituitary to secrete adrenocorticotropic hormone (ACTH), are consistently elevated in the cerebrospinal fluid of depressed patients compared with nondepressed control subjects (Heim et al. 2000; Nemeroff 1998a). When CRF is injected directly into the brains of laboratory animals, these animals have exhibited behavior similar to depression in humans. These observations suggest a stress-diathesis model for mood disorders. In other words, a genetic substrate might serve to diminish monoamine levels in synapses or to increase reactivity of the hypothalamic-pituitary-adrenal axis to stress. If there is no serious stress on the individual, the genetically determined threshold is not necessarily sufficient to induce depression. However, experiences of neglect or abuse in childhood may activate the stress response and induce elevated activity in CRF-containing neurons, which are known to be stress responsive and to be excessively active in depressed persons. These cells can become supersensitive in certain individuals, reacting dramatically to even mild stressors. Hammen et al. (2000) confirmed that in adult women, childhood adversity appears to sensitize women to stressor-induced depression in adult life.

In an elegantly designed study, Heim et al. (2000) studied 49 healthy women aged 18–45 years who were taking no hormonal or psychotropic medications. They divided the participants into four groups: 1) those with no history of child abuse or psychiatric disorder, 2) those with current major depression who were sexually or physically abused as children, 3) those without current major depression who were sexually or physically abused as children, and 4) those with current major depression but no history of childhood abuse. Those women in the study with a history of childhood abuse exhibited

increased pituitary, adrenal, and autonomic responses to stress compared with control subjects. This effect was particularly significant in women with current symptoms of depression and anxiety. The ACTH response to stress in women with a history of childhood abuse and a current major depression diagnosis was more than sixfold greater than the response in age-matched control subjects. The investigators concluded that hypothalamic-pituitary-adrenal axis and autonomic nervous system hyperreactivity related to CRF hyposecretion is a persistent consequence of childhood abuse that may contribute to the diathesis for adult depression. Other research has shown that the effects of child abuse on adult depressive symptoms are moderated by genetic polymorphisms within the corticotropin-releasing hormone type I receptor (CRHR 1) gene (Bradley et al. 2008). Hence, a wave of recent research suggests that gene-environment interaction must be taken into account in understanding which person gets depressed and which person is protected from depression in the face of childhood abuse.

Early stressors in childhood are inherent in a psychodynamic model that sees adult pathology as related to early traumas. However, the dynamic perspective also takes into account the meaning of a particular stressor. Clinicians must keep in mind that what may seem like a relatively mild stressor to an outside observer may have powerful conscious or unconscious meanings to the patient that greatly amplify its impact. Hammen (1995) noted that "the field has reached considerable consensus that it is not the mere occurrence of a negative life event, but rather the person's interpretation of the meaning of the event and its significance in the context of its occurrence" (p. 98). In a longitudinal study of the link between depressive reactions and stressors, Hammen et al. (1985) found that those stressors whose content matched the patient's area of self-definition were particularly likely to precipitate depressive episodes. In other words, in someone whose sense of self is partly defined by social connectedness, loss of a significant interpersonal relationship may precipitate a major depression. On the other hand, if someone's self-worth is especially linked to mastery and achievement, such a person might be more likely to have a depressive episode in response to a perceived failure at work or in school.

A recent report from Kendler et al. (2003) suggested that life events with particular meanings to the individual may be more closely linked to the onset of major depression in adult patients. In interviews with their twin sample from the population-based Virginia Twin Registry, they found that onset of major depression was predicted by higher ratings of loss and humiliation in the stressors. They also noted that events with a combination of humiliation (because of a separation initiated by a significant other) and loss were more depressogenic than pure loss events such as death. Humiliating events that directly devalue the individual in a core role were strongly linked to a

risk for depressive episodes. Hence a psychodynamic clinician would want to explore the meaning of all stressors to determine the unique way that the stressor affected the patient.

Psychodynamic Understanding of Depression

The history of psychoanalytic/psychodynamic approaches to depression begins with Sigmund Freud's classic work "Mourning and Melancholia" (Freud 1917/1963). Central to Freud's view was that early losses in childhood lead to vulnerability to depression in adulthood. He also observed that the marked self-depreciation so common in depressed patients was the result of anger turned inward. More specifically, he conceptualized that rage is directed internally because the self of the patient has identified with the lost object. In Freud's words, "Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, the forsaken object" (p. 249). In 1923, Freud noted that taking a lost object inside and identifying with it may be the only way that some people can give up an important figure in their lives. That same year, in "The Ego and the Id" (Freud 1923/1961), he postulated that melancholic patients have a severe superego, which he related to their guilt over having shown aggression toward loved ones.

Karl Abraham (1924/1927) elaborated on Freud's ideas by linking present with past. He suggested that depressed adults suffered a severe blow to their self-esteem during childhood and that adult depression is triggered by a new loss or new disappointment that stirs intense negative feelings toward both past and present figures who have hurt the patient through either real or imagined withdrawal of love.

Klein (1940/1975) noted that manic defenses, such as omnipotence, denial, contempt, and idealization, develop in response to the painful affects produced by "pining" for the lost love objects. These defenses are used in the service of 1) rescuing and restoring the lost love objects, 2) disavowing the bad internal objects, and 3) denying slavish dependency on love objects. Clinically, patients may express these manic operations through a denial of any aggression or destructiveness toward others, a euphoric disposition that is contrary to their actual life situation, an idealization of others, or a scornful and contemptuous attitude toward other people that serves to disavow the need for relationships. An integral aspect of the manic defensive posture is often a wish to triumph over parents and thus reverse the child–parent relationship. This desire for triumph may in turn give rise to guilt and depression. In Klein's view, this mechanism is partly responsible for the depression that frequently develops after success or promotion.

Klein's formulation is useful because it helps clinicians to understand how the psychological function of a manic episode can coexist with biological determinants. The defensive function of mania is most clearly evident in dysphoric manic patients (Post et al. 1989) whose anxiety and depression "break through" a manic episode, necessitating a resurgence of manic denial. Moreover, in a much more attenuated form, hypomanic defenses are typically enlisted to defend against the threat of depressive affects or grief. One patient, for example, described feeling "high" after learning of his mother's death. He felt powerful, expansive, and liberated from dependency. Despite these feelings, he was able to note how odd it was that he was not grief stricken.

In the 1950s, the contributions of Bibring (1953) appeared and differed substantially from those of Freud and Klein regarding the role of aggression. He believed that depression was better understood as a primary affective state unrelated to the aggression turned inward that Freud and Klein emphasized. He viewed melancholic states as arising from the tension between ideals and reality. Three highly invested narcissistic aspirations—to be worthy and loved, to be strong or superior, and to be good and loving—are held up as standards of conduct. However, the ego's awareness of its actual or imagined inability to measure up to these standards produces depression. As a result, the depressed person feels helpless and powerless. He believed that any wound to one's self-esteem might precipitate a clinical depression. Hence narcissistic vulnerability was a key to Bibring's understanding of what set a depressive process in motion. He did not view the superego as having a key role in the process.

After studying the records of depressed children at the Hampstead Clinic in the United Kingdom, Sandler and Joffe (1965) concluded that children became depressed when they felt they had lost something essential to self-esteem but felt helpless to do anything about the loss. They emphasized that the loss was more than just a real or imagined love object but also a state of well-being conferred upon the individual by the object. This state becomes a type of "paradise lost" that becomes idealized and intensely desired even though it is unattainable.

Jacobson (1971a) built on Freud's formulation by suggesting that depressed patients actually behave as though they were the worthless, lost love object, even though they do not assume all the characteristics of that lost person. Eventually this bad internal object—or the lost external love object—is transformed into a sadistic superego. A depressed patient then becomes "a victim of the superego, as helpless and powerless as a small child who is tortured by his cruel, powerful mother" (p. 252).

> Ms. J was a 49-year-old homemaker who became psychotically depressed. She became convinced that she was thoroughly worthless, and she was pre-

occupied with how her father had beaten her as a child because she was such a "bad little girl." At times the bad introject of the abusive, hated father was absorbed into the patient's self-view, and she would cut herself both as self-punishment and as a way of attacking the internal object. At other times, the father would be experienced as a separate internal object, or a harsh superego, who would rebuke her for being bad. In these instances, Ms. J would hear a hallucinated voice saying, "You are bad" and "You deserve to die."

The internal object world of Ms. J indicates how, in psychotic depression, there may be a fusion of the self with the object on the one hand and a reactivation of an internal object relationship in which a tormenting bad object, or primitive superego, persecutes a bad self on the other. Jacobson believed that mania could be understood as a magical reunion of the self with the harsh superego figure, thus changing that figure from a punitive tormenter into a loving, all-good, forgiving figure. This idealized object may then be projected onto the external world to establish highly idealized relationships with others whereby all aggression and destructiveness are denied.

Arieti (1977) postulated a preexisting ideology in persons who become severely depressed. He observed while treating severely depressed patients that they often had a pattern of living for someone else instead of for themselves. He termed the person for whom they lived the *dominant other*. The spouse is often the dominant other in this formulation, but sometimes an ideal or an organization can serve the same function. He used the term *dominant goal* or *dominant etiology* when a transcendent purpose or aim occupied this place in the individual's psychological world. These individuals feel that living for someone or something else is not working out for them, but they feel unable to change. They may believe that life is worthless if they cannot elicit the response they wish from the dominant other or if they cannot achieve their impossible goal.

Much can be learned about depression from attachment theory. John Bowlby (1969) viewed the child's attachment to his or her mother as necessary for survival. When attachment is disrupted through loss of a parent or through an unstable ongoing attachment to the parent, children view themselves as unlovable and their mothers or caregivers as undependable and abandoning. Hence in adult life such children may become depressed whenever they experience a loss because it reactivates the feelings of being an unlovable and abandoned failure.

Several themes run throughout the various psychodynamic formulations, which are summarized in Table 8–1. Almost all psychoanalytic views emphasize a fundamental narcissistic vulnerability or fragile self-esteem in depressed patients (Busch et al. 2004). Anger and aggression also are implicated in most theories, particularly in connection with the guilt and self-denigration that they produce. In addition, the seeking of a highly perfec-

TABLE 8–1. Major historical contributions to psychodynamic models of depression/dysthymia

Freud (1917/1963)	Anger turned inward
Abraham (1924/1927)	Present loss reactivates childhood blow to self-esteem
Klein (1940/1975)	Developmental failure during depressive position
Bibring (1953)	Tension in the ego between ideals and reality
Sandler and Joffe (1965)	Helplessness in response to childhood loss of real or imagined love object
Bowlby (1969)	Loss reactivates feeling of being unlovable and abandoned secondary to insecure attachment
Jacobson (1971a, 1971b)	Lost love object transformed into sadistic superego
Arieti (1977)	Living for dominant other

tionistic caretaking figure with the certainty that one will not find such a person is a part of the depressive picture. A demanding and perfectionistic superego appears to play a central role and can become tormenting in its demands on the individual. In some cases, a vicious cycle is established (Busch et al. 2004). Someone who is depressed may try to compensate by idealizing either oneself or a significant other. This idealization, however, only increases the likelihood of eventual disappointment, which then triggers depression because these high standards have not been met. This failure also leads to devaluation of the self and self-directed anger.

A contemporary psychodynamic model of depression would understand that early experiences of trauma leave the child to develop problematic self and object representations. In the case of physical and sexual abuse, the child internalizes a bad self deserving of abuse who feels hypervigilant about victimization. The object representation is likely to be that of an abusive, punitive figure that attacks the self. The feeling of being tormented or persecuted by this abusive internal object fits well with observations of a punitive superego. Similarly, early loss of a parent leads a child to develop a sense of an abandoned self that cannot have its needs met in the usual way by a parent. The child also internalizes an abandoning object representation and grows up with a sense of loss and longing that becomes reactivated with any adult stressor involving loss. Hence the effects of losses are magnified when they occur in adult life. Because a child's self-esteem is largely based on how the child is treated in early family interactions, a vulnerable self-esteem is also a legacy of childhood loss and trauma. The forging of the child's personality in the context of problematic relationships with parents and other significant figures will likely result in adult relational difficulties. Thus adults with this background may have difficulties forming and maintaining rela-

tionships and may be more vulnerable to loss and narcissistic injury from others.

The study of defense mechanisms is another component of psychoanalytic theory that is relevant to a psychodynamic model of depression. Defense mechanisms are established early in life to manage painful affect states. The work of Kwon (1999; Kwon and Lemmon 2000) suggests that certain defense mechanisms may contribute to the development of depression whereas others may help protect against depression. Turning against the self, which involves exaggerated and persistent self-criticism, is an immature defense that has an additive effect on negative attributional style in the development of dysphoria. Other immature defense mechanisms also appear to increase the risk for depression and other psychiatric disorders (Vaillant and Vaillant 1992). On the other hand, certain higher-level defense mechanisms, such as principalization (also called intellectualization), which involves the reinterpretation of reality through general and abstract principles, may positively moderate the influence of attributional styles on levels of dysphoria. Hence adding a psychodynamic perspective on defenses may facilitate understanding and treatment of depression (Hayes et al. 1996; Jones and Pulos 1993).

Yet another principle of psychodynamic thinking is a focus on what is unique about each patient as opposed to seeing patients as part of one large group. In this regard, psychodynamic models of depression take into account unique qualities of defense mechanisms and object relations in each depressed person. For example, Blatt (1998, 2004) studied large populations of depressed patients and noted that two underlying psychodynamic types emerge from his work. The *anaclitic* type is characterized by feelings of helplessness, loneliness, and weakness related to chronic fears of being abandoned and unprotected. These individuals have longings to be nurtured, protected, and loved. They are characterized by vulnerability to disruptions of interpersonal relationships, and they typically use the defense mechanisms of denial, disavowal, displacement, and repression. By contrast, *introjective* patients who are depressed are primarily concerned with self-development. Intimate relationships are viewed as secondary, and they use different defense mechanisms: intellectualization, reaction formation, and rationalization. They are exceedingly perfectionistic and competitive and are excessively driven to achieve in work and school. The anaclitic types manifest their depression primarily in dysphoric feelings of abandonment, loss, and loneliness. The introjective types manifest their depression by feelings of guilt and worthlessness. They also have a sense of failure and a perception that their sense of autonomy and control has been lost.

A significant shift in the conceptualization of depression occurred in DSM-5. Situations of bereavement were no longer excluded from consideration of the major depressive disorder diagnosis. When individuals who

were undergoing bereavement-related depression were studied, there were a few unique features of these people compared with those whose depression was not triggered by bereavement (Kendler et al. 2008). However, the similarities between bereavement-related depression and depression triggered by other stressful life events substantially outweighed their differences. Moreover, when suicidal ideation in a group of 60 recently bereaved widowers and widows was compared with 60 matched married comparison subjects (Stroebe et al. 2005), it was clear that bereaved persons are at excess risk of suicidal ideation compared with nonbereaved people. The heightened suicidal ideation in bereavement is linked to extreme emotional loneliness and severe depressive symptoms and therefore warrants the same clinical attention as one would give to a nonbereaved patient in the midst of a major depressive episode.

Psychodynamics of Suicide

Many different psychiatric disorders can culminate in the tragic outcome of suicide. Suicide is most prominently associated with major affective disorders, however, so it is therefore considered in detail in the context of this chapter. Before examining the psychodynamic perspective on suicide, a caveat is in order. Determinants of suicidal behavior may be biological as well as psychological. The psychodynamics revealed by psychotherapeutic work with suicidal patients may in some respects be *secondary* to neurochemical changes, so all available somatic treatment modalities must be used aggressively along with the psychotherapeutic approach. In many cases, psychotherapy alone is insufficient with seriously suicidal patients. In one comparison study (Lesse 1978), only 16% of the severely depressed psychotherapy patients had a positive outcome, whereas 83% of the patients who received both psychotherapy and pharmacotherapy and 86% of those who received electroconvulsive therapy (ECT) had good results. Saving the patient's life is far more important than theoretical purity.

Suicidal behavior and ideation, like all other acts and thoughts, are the end products of the principles of overdetermination and multiple function (see Chapter 1). Motivations for suicide are highly varied and often obscure (Meissner 1986). The clinician must therefore listen carefully to each patient, noting the particular transference-countertransference developments before reaching any closure on the dynamic underpinnings of suicide.

In keeping with his understanding of the dynamics of depression, Freud (1917/1963) assumed that the ego could kill itself only by treating itself as an object, so he postulated that suicide results from displaced murderous impulses—that is, destructive wishes toward an internalized object are di-

rected instead against the self. After the development of the structural model (Freud 1923/1961), Freud redefined suicide as the victimization of the ego by a sadistic superego. Karl Menninger's (1933) view of suicide was a bit more complex. He believed that at least three wishes might contribute to a suicidal act: the wish to kill, the wish to be killed, and the wish to die. The wish to kill may be directed not only toward an *internal* object. Clinical experience confirms again and again that suicide is often designed to destroy the lives of the survivors. Depressed patients often feel, for example, that suicide is the only satisfactory revenge against their parents. The patient's spouse may similarly be the "target" of a suicide.

A recurring theme in the object relations of suicidal patients is the drama between a sadistic tormentor and a tormented victim. As in the case of Ms. J described earlier, there is often a persecuting internal object that makes the patient miserable. Alternatively, the patient who identifies with the persecutor may torment everyone in his or her environment. In some cases, the patient may believe that the only possible outcome of the drama is to submit to the tormentor through suicide (Meissner 1986). This internal persecuting figure has been referred to as the "hidden executioner" (Asch 1980).

In other cases, aggression plays a far less prominent role in the motivation for suicide. Fenichel (1945) noted that suicide may be the fulfillment of a reunion wish, that is, a joyous and magical rejoining with a lost loved one or a narcissistic union with a loving superego figure. Object loss frequently lies behind suicidal behavior, and many suicidal patients reveal strong dependency yearnings toward a lost object (Dorpat 1973). In this regard, suicide may be a regressive wish for reunion with a lost maternal figure. The last words of the Reverend Jim Jones in the 1978 mass homicide and suicide in Guyana were "Mother…Mother," spoken just before he shot himself in the head. A pathological grief process is often involved in suicides, particularly those that occur on the anniversary of the death of a loved one. Research has demonstrated, for example, that there is a statistically significant correlation between suicide and the anniversary of a parent's death (Bunch and Barraclough 1971). When an individual's self-esteem and self-integrity depend on attachment to a lost object, suicide may seem to be the only way to restore self-cohesion.

> Ms. K was a 24-year-old psychotically depressed woman who, 2 years earlier, had lost her twin brother to suicide. Following his death, she had withdrawn from life, intent on killing herself. Moreover, she had become psychotically identified with her brother to the point that she identified herself as male and as having his first name. Her illness had been refractory to antidepressant medication, lithium carbonate, and ECT. She felt that she could not continue living in the absence of her brother. Ms. K ultimately committed suicide on the anniversary of her brother's death.

To assess suicide risk with any given patient, these psychodynamic themes must be put in the context of a set of predictors of suicide risk. A prospective examination of 954 patients (Clark and Fawcett 1992) revealed that it was useful to differentiate short-term from long-term risk factors in attempting to predict suicide. Seven factors predicted suicide within 1 year of entry into the study: panic attacks, psychic anxiety, severe loss of pleasure and interests, depressive turmoil involving a rapid switching of mood from anxiety to depression to anger or vice versa, alcohol abuse, diminished concentration, and global insomnia. Long-term risk factors included hopelessness, suicidal ideation, suicidal intent, and a history of previous suicide attempts. Hopelessness, which has repeatedly been shown to be a better predictor of suicide risk than depression, may be linked to a rigidly held view of the self that cannot be shifted despite repeated disappointments. If one cannot live up to rigidly held expectations of what the self should be, hopelessness may result, and suicide may seem the only way out. In a similar vein, Arieti (1977) noted that certain patients who cannot shift their dominant ideology or their expectation of the dominant other may also be at high risk for suicide. In assessing suicidal ideation, a higher risk exists when the ideation is *ego-syntonic*—these patients find suicidal ideation acceptable and appear to have given up the fight against the urge to kill themselves.

To put suicide in a psychodynamic context, clinicians must understand the nature of the precipitating event, the conscious and unconscious motivations, and the preexisting psychological variables that increase the likelihood of acting on suicidal thoughts. Through the use of projective psychological testing, researchers (Smith 1983; Smith and Eyman 1988) have studied and identified four patterns of ego functioning and internal object relations paradigms that differentiate individuals who made serious attempts from those who merely made gestures to control significant others. The serious attempters exhibited 1) an inability to give up infantile wishes for nurturance, associated with conflict about being openly dependent; 2) a sober but ambivalent view toward death; 3) excessively high self-expectations; and 4) overcontrol of affect, particularly aggression. Although this pattern applies more to men than to women (Smith and Eyman 1988), an inhibitory attitude toward aggression distinguishes serious female attempters from those who make mild gestures. These test findings imply that the preexisting psychological structures that favor suicide are more consistent across individual patients than are the various motivations behind a particular suicidal act.

Some risk factors for suicide seem to line up along gender lines. Impulsive aggressive personality disorders and alcohol or drug abuse are two independent predictors of suicide in men who have major depression (Dumais et al. 2005). For women, sexual abuse is strongly associated with a history of suicide attempts as well as suicidal intent (Bebbington et al. 2009). Hence,

women who have been sexually abused should be identified as part of an assessment of suicidal women in order that appropriate treatment focus is brought to bear. For both men and women, comorbid anxiety disorders clearly amplify the risk of suicide attempts in persons with mood disorders and should also be taken into account (Sareen et al. 2005).

Treatment Considerations

Outcome Studies

Although it is often stated that cognitive-behavioral therapy as a treatment for depression has a far more extensive evidence base than psychodynamic psychotherapy, the growing body of literature demonstrating the efficacy of psychodynamic psychotherapy for depression is seldom cited. Driessen et al. (2013) compared the efficacy of psychodynamic psychotherapy with that of cognitive-behavioral therapy (CBT) in a randomized controlled trial (RCT) involving 341 ouptatients seeking treatment for major depressive disorder, making it the largest RCT of dynamic psychotherapy ever conducted. Each group received 16 sessions of treatment. No statistically significant treatment differences were found for any of the outcome measures. The average posttreatment remission rate was 22.7%. The key finding was that psychodynamic psychotherapy was noninferior to CBT.

Two meta-analyses confirm the efficacy of psychodynamic psychotherapy for treatment of depression, both of which focused on short-term psychodynamic psychotherapy (STPP). Driessen et al. (2010) included 23 studies totaling 1,365 subjects. STPP was found to be significantly more effective than control conditions, and the changes from pretreatment to posttreatment were large and were maintained at follow-ups for up to 1 year. When compared with other psychotherapies, no significant differences were found at 3-month or 12-month follow-up. Those treatments that focused more on the supportive end of the continuum were equally as effective as those that were more expressive in focus.

Cuijpers et al. (2008) conducted seven meta-analyses involving a total of 53 studies in which seven major types of psychotherapy for mild to moderate adult depression were directly compared with one another. Each major type of treatment had been examined in at least five randomized comparative trials, and psychodynamic psychotherapy was one of the treatments considered. The investigators found no evidence that one of the treatments was more or less efficacious, with the exception of interpersonal therapy (which was somewhat more efficacious) and nondirective supportive treatment (which was somewhat less efficacious). They concluded that there

were no large differences in efficacy between the major psychotherapies for mild to moderate depression.

Short-term psychodynamic psychotherapy may have effectiveness that is similar to that of the antidepressant fluoxetine in mild to moderate depression. Salminen et al. (2008) studied 51 patients with major depressive disorder of mild to moderate severity and randomly assigned them either to fluoxetine 20–40 mg/day for 16 weeks or to STPP for a similar duration. Both treatments were highly effective in reducing symptoms as well as improving functional ability.

A randomized controlled pilot investigation (Gibbons et al. 2012) found that STPP is effective for depression in a community mental health system. Forty treatment-seeking patients with moderate to severe depression were randomly assigned to 12 weeks of psychotherapy with either a community therapist trained in brief dynamic therapy or a therapist providing treatment as usual (TAU).

When the results were examined, it was determined that blind judges were able to discriminate the dynamic sessions from the TAU sessions on adherence to dynamic interventions. Moreover, although this pilot study did not have adequate statistical power to assess efficacy, moderate to large effect sizes in favor of the dynamic psychotherapy over the TAU therapy were noted. Fifty percent of patients treated with dynamic therapy moved into a normative range on depressive symptoms compared with only 29% of patients treated with TAU.

One novel study on short-term psychodynamic psychotherapy for depression described its effectiveness in a naturalistic setting using a hybrid effectiveness/efficacy treatment research model (Hilsenroth et al. 2003). Twenty-one patients with major depressive disorder, depressive disorder not otherwise specified, dysthymia, or adjustment disorder with depressed mood received once- or twice-weekly sessions. In this study, unlike most previous studies, patients were not excluded due to comorbidities. In addition, treatment duration was not fixed, as is the case in randomized controlled trials, but was determined by clinician, patient, and progress in the work. All patients completed a minimum of 9 sessions, and the mean number of sessions was 30 during an average 7-month period. DSM-IV (American Psychiatric Association 1994) depressive and global symptomatology, as well as relational, social, and occupational functioning were assessed using clinician ratings and self-reports pretreatment and posttreatment. Statistically significant positive changes occurred in all areas of functioning. A significant direct process–outcome link was observed between therapeutic techniques and improvement in depressive symptoms. Specifically, focusing the session on affect and the expression of emotion appeared most important. The authors acknowledged the limitations of the small sample size and

mild to moderate levels of impairment. Nonetheless, the study is a first in terms of addressing effectiveness in a naturalistic setting.

More recent studies have started investigating combining psychotherapy with antidepressants in the treatment of depression. In one Dutch study, 167 outpatients with major depression were randomized to 6-month clinical trials of antidepressants or combined therapy (de Jonghe et al. 2001). Initial antidepressant treatment was with fluoxetine, and a successive step protocol using amitryptyline and moclobemide was utilized for intolerance or inefficacy. Combination treatment added 16 sessions of brief psychodynamic supportive psychotherapy. Statistically significant differences in success rates, consistently favoring combination therapy, were apparent at 8, 16, and 24 weeks of treatment. At 6 months, 40% of patients receiving antidepressants alone had stopped taking their medication, whereas only 22% of those with combination therapy had stopped. The mean success rate for the pharmacotherapy group was 40.7% and almost 60% for the combination group at 24 weeks. Patients undergoing combined treatment were less likely to stop taking their medication or drop out of treatment and were therefore significantly more likely to recover.

Another study supporting the superiority of combination therapy over pharmacotherapy alone for major depression was performed by Burnand et al. (2002). In this Swiss study, 74 patients were randomized to clomipramine alone or clomipramine and psychodynamic psychotherapy treatment groups in an acute outpatient treatment setting for 10 weeks. Patients taking clomipramine alone received supportive care that was comparable to the amount of structured psychotherapy that the combination group was receiving. Improvement was noted in both groups. However, patients in the combination treatment group had lower rates of treatment failure and better work adjustment at 10 weeks. In addition, this group had better global functioning and lower hospitalization rates at discharge. Short-term psychodynamic psychotherapy also proved cost-effective: a cost savings of $2,311 per patient in the combined treatment group resulted from fewer lost work days and less hospitalization. This amount exceeded the cost of providing the psychotherapy.

Randomized controlled studies investigating long-term psychodynamic therapy and psychoanalysis with depressed patients remain unavailable. Many clinicians recognize that there is a subgroup of depressed patients who will require such treatment. Blatt et al. (1995) reanalyzed data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program and found that highly perfectionistic and self-critical patients (i.e., the introjective subtype of depressed patients) did not respond well to any of the four treatment cells, which included 16 weeks of cognitive therapy, 16 weeks of interpersonal therapy, 16 weeks of imipramine plus

clinical management, and 16 weeks of placebo plus clinical management. Two naturalistic follow-along studies (Blatt 1992; Blatt et al. 1994) suggested that long-term psychodynamic therapy may be effective with the self-critical and perfectionistic patients who do not respond to brief modalities. Many of these patients probably have significant obsessive-compulsive or narcissistic characterological traits. These perfectionistic patients may also be at high risk for suicide (Blatt 1998; Hewitt et al. 1997), so the investment of time, energy, and resources may be well justified. Further research is needed to confirm this hypothesis.

Treatment Principles

Mania

Most manic patients will not benefit from psychotherapeutic interventions until their mania is first pharmacologically controlled. Much of the subsequent treatment involves preventing relapse by focusing on problems with noncompliance and lack of insight into the illness. Several major psychodynamic themes often present in bipolar patients must be addressed. In keeping with the general denial of their illness, these patients often argue that their manic or hypomanic symptoms are not part of an illness but rather a reflection of who they really are. Patients with bipolar illness are notoriously lacking in insight. In a study of 28 manic patients treated on an inpatient unit (Ghaemi et al. 1995), measures of insight were made at admission and discharge. The investigators found that even when all other symptoms of mania had improved or remitted, insight remained notably absent.

Often related to this denial is another psychodynamic theme involving splitting or psychic discontinuity. Many bipolar patients continue to deny the significance of their prior manic episodes when they are euthymic. They may claim that the behavior was simply the result of not taking good care of themselves, and they often adamantly insist that what happened before will never happen again. In this form of splitting, the self representation involved in the manic episode is viewed as entirely disconnected with the self in the euthymic phase. This lack of continuity of self does not appear to bother the patient, whereas it may exasperate family members and clinicians. The clinician managing the patient needs to work psychotherapeutically to piece together the self-fragments into a continuous narrative in the patient's life so that the need for maintenance pharmacotherapy becomes more compelling to the patient. Sometimes tape-recording manic episodes (with the patient's permission) and playing back the recordings when the patient is euthymic may help convince the patient of the connection between the manic self and the euthymic self.

From a Kleinian perspective, the fundamental psychotherapeutic task with the bipolar patient may be to facilitate the work of mourning. Early parental loss, particularly loss of the mother, is strongly associated with development of bipolar illness (Mortensen et al. 2003). In fact, children who lose their mother before the age of 5 years have a four times higher risk of developing bipolar disorder. There is also a strong linkage between childhood physical trauma and mania in adulthood (Levitan et al. 1998), and it is possible that the need to deny aggression has roots in the earliest years of life. The threat of aggressive, persecutory feelings leads to the need for manic defenses to deny them. Following a manic episode, patients may be acutely aware of their own destructiveness and may feel remorseful about the harm they have caused others during the manic phase. Psychotherapists may then be presented with an optimal moment to help patients integrate the loving and aggressive sides of their internal self and object representations. Continuing to split off these aspects of themselves offers patients temporary relief from the pain but no chance of ultimately resolving their depressive anxieties. Klein (1940/1975) noted that as feelings of persecution and aggression decrease, manic defenses become less necessary to the patient. Hence, another goal is to help the patient to become more capable of internalizing a relationship in which good predominates over bad and love predominates over hate.

In a 2-year prospective study of relapse in 61 outpatients with bipolar illness (Ellicott et al. 1990), relapse could not be explained by changes in lithium levels or medication compliance. However, there was a significant association between stressful life events and relapse. The investigators concluded that psychological interventions at times of high stress are crucial to preventing recurrences. The dynamic psychiatrist must be tuned in to the significance of specific stressors in the patient's life and monitor them while also managing the mood stabilizer.

Lithium and other mood stabilizers often take on special meanings to bipolar patients. For some patients, the medication represents a method of depriving them from the ego-syntonic euphoria of their manic periods. Medication may also remind patients of family members who have suffered from bipolar illness and had adverse consequences such as suicide. Jamison (1995) described her own battle with bipolar illness and commented on the extraordinary value of psychotherapy in helping her to continue taking lithium and understand her fears of complying with the medication regimen. Through psychotherapy, she discovered her secret fears about medication: "In fact, underneath it all, I was actually secretly terrified that lithium might *not* work: What if I took it, and I still got sick? If, on the other hand, I didn't take it, I wouldn't have to see my worst fears realized" (p. 103).

Although problems with noncompliance must be vigorously addressed, the pharmacotherapy of bipolar disorder has limited effectiveness in preventing recurrences over time. Only about 40% of patients who take lithium are relapse-free at 5-year follow-up (Maj 1999). High rates of employment problems and family difficulties are the rule rather than the exception (Miklowitz and Frank 1999). Hence, there is a consensus that psychotherapy must have broader goals than simply improving compliance; it should include identifying stressors, enhancing family functioning, and processing the impact of the illness on the patient and others. Miklowitz et al. (2003) demonstrated in a rigorously designed study that adding family psychoeducation to pharmacotherapy enhances both drug adherence and symptomatic adjustment in the post-episode period. In a review of the evidence of adjunctive psychotherapy for bipolar disorder, Miklowitz (2008) found that adjunctive psychotherapy enhanced the symptomatic and functional outcomes of bipolar disorder over a 2-year period. Treatments that emphasize medication adherence and early recognition of mood symptoms have stronger effects on mania, but Miklowitz found that treatments emphasizing cognitive and interpersonal coping strategies have stronger effects on depression. These data were based on 18 trials of individual and group psychoeducation, systematic care, family therapy, interpersonal therapy, and cognitive-behavioral therapy.

Salzman (1998) has argued persuasively for the integration of pharmacotherapy and psychotherapy in the treatment of bipolar patients. Building a therapeutic alliance is the first order of business and is accomplished through psychotherapeutic exploration, empathy, and education rather than use of debating tactics. Creation of a mood chart may also be helpful. Transference shifts from idealization to devaluation are common, and countertransference acting-out in response to frustration and anger is an ongoing risk.

Jamison (1995) shared the view that combined treatment is necessary: "Ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all.…No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my mania and depressions. I need both" (p. 89).

Depression

The first step in the psychotherapeutic treatment of depression, regardless of whether the patient is in a hospital or is an outpatient, is the establishment of a therapeutic alliance. To build the necessary rapport, the clinician must simply listen and empathize with the patient's point of view. Perhaps the most common error both of family members and of beginning mental health

professionals is to try to cheer up the patient by focusing on the positive. Comments, such as "You have no reason to be depressed—you have so many good qualities" or "Why should you be suicidal? There's so much to live for" are likely to backfire. These "cheerleading" comments are experienced by depressed patients as profound failures of empathy, which may lead patients to feel more misunderstood and alone and therefore more suicidal.

On the contrary, clinicians who work with these patients must convey their understanding that there is indeed a reason to be depressed. They can empathize with the painfulness of the depression while also enlisting the patient's help in a collaborative search for its underlying causes. The initial approach must be supportive but firm (Arieti 1977; Lesse 1978). Premature interpretations, such as "You're not really depressed—you're angry," will also be experienced as unempathic and off the mark. The clinician will be most helpful simply by listening and attempting to comprehend the patient's understanding of the illness.

A psychodynamic therapist would carefully evaluate the nature of the stressor that appeared to trigger a depression. Did the stressor involve humiliation and loss? Did it reawaken early childhood losses or traumas? What was the particular meaning of the stressor to the patient? The dynamic therapist would want to know what the patient associates with the stressor. Is the event reminiscent of other feelings, thoughts, or fantasies that have been present in the patient's mind? A dynamic therapist might also encourage the patient to bring in dreams that may shed light on what is going on unconsciously. By way of summary, as noted in Chapter 1, the psychodynamic therapist is pursuing the "person" more than trying to eradicate the "illness."

In the course of history-taking and evaluation of the stressor, psychodynamic therapists also listen closely to the themes that occur around relationship patterns and the patient's self-esteem. They would be considering the various psychodynamic themes enumerated above as they assess which themes may most accurately be involved in the pathogenesis of the patient's depression. Is their anger turned inward? Is there a concern that their destructiveness or greed has harmed loved ones? Is there a perfectionistic view of the self that seems impossible to attain? Is the patient tormented by a vicious and unrelenting superego that is constantly expecting more than the patient can deliver? Is there a pining for lost love objects in the present or the past that makes the patient feel hopeless? Has the patient lived for a "dominant other" rather than fulfilling the patient's own unique dreams and desires? Is the depression more the anaclitic type, with prominent feelings of helplessness, weakness, and loneliness, or is it more the introjective type, for which self-development seems to be of greater importance than finding a nurturing and protective love object? Similarly, what defense mechanisms does the patient use to manage painful affect states?

While exploring these themes in the patient's life narrative, the psychodynamic therapist would also be carefully observing transference, countertransference, and resistance phenomena. The way the patient relates to the therapist and the feelings evoked in the therapist by the patient will provide clues to familiar patterns of relationship problems that occur outside the therapy. The pattern of resistance may reflect the patient's defenses in other life situations as well. Eventually, the therapist develops a formulation of the patient's difficulties that involve both early developmental issues and the current situation. The meaning of the stressor will probably figure prominently in the formulation.

The formulation attempts to address questions such as the following: What events apparently precipitated the depression? What narcissistically valued aspiration has the patient failed to achieve? What is the patient's dominant ideology? Who is the dominant other for whom the patient is living and from whom the patient is not receiving the desired responses? Is there guilt connected with aggression or anger, and if so, with whom is the patient angry? Is there frustration of the self's strivings for selfobject responses? Does the patient have primarily an anaclitic type of depression (Blatt et al. 1995), in which therapeutic change will involve interpersonal relationships? Or does the patient have more of an introjective depression, in which self-definition and self-worth will be more central?

While the clinician listens to the patient's story and develops hypotheses about the psychodynamic basis of the depression, the patient forms a transference attachment to the therapist. In Arieti's (1977) terms, the therapist becomes a "dominant third," in addition to the dominant other in the patient's life. Many of the same concerns that are problematic in the patient's primary relationships will also surface in the transference. Arieti pointed out that building a therapeutic alliance may require therapists to conform to certain of the patient's expectations during the initial stages of psychotherapy, thus facilitating the repetition of the patient's pathology in the therapeutic relationship. When enough information has been gathered, the therapist may have to shift to a more expressive approach and interpret to the patient the "dominant other" pattern that has caused so much difficulty. Arieti observed that "the patient must come to the conscious realization that he did not know how to live for himself. He never listened to himself; in situations of great affective significance he was never able to assert himself. He cared only about obtaining the approval, affection, love, admiration, or care of the dominant other" (p. 866). After this realization, a good deal of anger toward the dominant other may surface.

After the dominant ideology has been laid bare, the therapist's task is then to help the patient conceive of new ways of living. In Bibring's (1953) terms, either the idealized aspirations must be modified sufficiently to be re-

alized, or they must be relinquished and replaced with other goals and objectives. At the prospect of developing new life patterns and purposes, these patients may depend on their therapist for answers. If therapists collude by telling their patients what to do, they will simply reinforce any feelings of low self-esteem and ineffectiveness (Betcher 1983; Maxmen 1978). Pleas from patients to solve their dilemmas can simply be turned back to them with the explanation that they are in the best position to make alternative life plans.

Central to the psychodynamic approach with depressed patients is the establishment of the interpersonal meaning and context of their depression. Unfortunately, patients often tenaciously resist these interpersonal implications (Betcher 1983). They frequently prefer to view their depression and their suicidal wishes as occurring in a vacuum, fervently insisting that no one is to blame but themselves. Careful attention to transference-countertransference developments may lead to breakthroughs with this form of resistance. In both psychotherapy and hospital treatment, patients recapitulate their internal object relationships as well as their patterns of relatedness with external figures. Depressed patients, in particular, engender strong feelings. In the course of such treatment, the therapist may experience despair, anger, wishes to be rid of the patient, powerful rescue fantasies, and myriad other feelings. All these emotional responses may reflect how others in the patient's life feel as well. These interpersonal dimensions of the depression may be involved in causing or perpetuating the condition. To examine the impact of the patient's condition on others, the therapist must enlist the patient's collaboration by using these feelings constructively in the therapeutic relationship. Many refractory cases of depression have become deadlocked in the repetition of a characteristic pattern of object relatedness that has strong characterological underpinnings and is therefore difficult to alter.

> Mr. L was a respected chemist who required hospitalization when he became suicidally depressed at the age of 41. While Mr. L had been an outpatient, every known antidepressant medication had been tried in therapeutic doses with monitored serum levels, and ECT had been used during the first weeks of his hospital stay. None of these somatic interventions had alleviated his depression in the least. Nevertheless, the patient continued to maintain that he was a victim of a "chemical imbalance" that was the doctor's responsibility to restore. Mr. L complained of self-doubt, feelings of worthlessness, inability to sleep, inability to work or concentrate, and hopelessness about the future. He felt that all his accomplishments were meaningless and that he had driven his wife to distraction by his repeated demands to comfort him. Mrs. L despaired because everything she offered her husband seemed to be of no help whatsoever. Whenever she attempted to point out positive aspects of her husband's life, he would respond with a "yes, but" comeback, dismissing her points as irrelevant.

The resident in charge of Mr. L's treatment and the other unit staff members on the treatment team shared Mrs. L's frustration. Mr. L demanded that they attend to his needs but then dismissed all their suggestions and insights as useless. The entire treatment staff felt de-skilled, impotent, and exhausted in the face of Mr. L's depression. Whenever the various residents on call during the evening hours made rounds on the hospital unit, Mr. L engaged them in long discussions about his depression. He would list the medications that had been tried and would expound on the role of neurotransmitters in depression. He would then ask for advice on his condition. Inevitably, the resident making rounds would be drawn into this discussion in an attempt to alleviate the suffering of this obviously intelligent and well-informed individual. Every suggestion made by any resident, however, would be discounted by Mr. L as "not helpful." By the end of these discussions, the on-call residents would feel that all the time spent with Mr. L was for naught, and they would leave feeling drained and devalued.

The treatment team presented their dilemma with Mr. L to the resident's supervisor, who pointed out how the patient's internal world was being recreated in the milieu. By assuming the role of the "help-rejecting complainer," Mr. L was reestablishing an internal object relationship characterized by a long-suffering and victimized self representation connected to an impotent and useless object representation. Mr. L used the reactivation of this internal object relationship to torment everyone around him. He was thus able to discharge an enormous reservoir of rage stemming from his childhood interactions with his mother, whom he felt had failed to provide for his needs.

As a result of this consultation, a dramatic shift took place in the treatment approach. The resident and the nursing staff primarily involved with Mr. L were able to disengage from their heroic therapeutic efforts and began to enlist the patient's collaboration in figuring out what was happening. No longer a passive recipient of "medical" treatment, the patient was now involved as an active collaborator in a psychological process of reflection and understanding.

The object relations paradigm that was being acted out in the milieu was clarified and described for the patient. At the same time, the case social worker explained the psychoanalytically based understanding to Mrs. L to facilitate alleviation of her extraordinary guilt and to help her understand that the present situation was a recapitulation of an unresolved childhood experience. When the treatment team stopped responding like Mr. L's internal object representation, Mr. L began presenting himself differently. He was initially enraged at their suggestion that he should accept any responsibility for his condition. The resident explained to him, however, that everything possible in terms of pharmacological interventions had been tried and that now Mr. L would have to consider his own contributions to the feeling that he was "stuck" in the depths of despair. This change in approach presented Mr. L with a new object relationship to contend with. After his initial stubbornness, he did a good deal of psychological work. He got in touch with his rage at his mother for not giving him the validation and love that he felt he required, as well as his delight in tormenting his wife to get back at his mother.

The case of Mr. L illustrates how a severe depression that is refractory to conventional somatic treatments may be related to formidable characterological resistances that cause the patient to become "stuck" in an unresolved self–object relationship. As described in Chapter 6, a breakthrough in such treatment can occur when the treatment staff disconfirm the patient's expectation that they will respond like the projected object representation; instead, the staff members provided a new model of understanding as well as a new series of objects and interactions for internalization by the patient.

Another aspect of the breakthrough with Mr. L was that staff members realized that he was not only a victim of an illness but also a victimizer of those around him. In discussing the secondary gain frequently associated with depression, Bibring (1953) noted that some depressed patients exploit their illnesses to justify their veiled expressions of destructive and sadistic impulses toward others. Mr. L had forced his wife into a maternal role with him, only to deem her maternal treatment of him worthless. In commenting on the hidden sadism frequently found in the depressed patient, Jacobson (1971b) noted: "The depressive never fails to make his partner, often his whole environment, and especially his children feel terribly guilty, pulling them down into a more and more depressed state as well" (p. 295). Indeed, the entire treatment staff had begun to feel as Mrs. L did. They felt increasingly guilty because they could not find any way to intervene therapeutically with Mr. L, and they became more depressed and drained as a result of each successive failure. Jacobson also pointed out that some depressed patients (such as Mr. L) may establish a vicious circle that drives their partners away just when their love is most needed. Spouses of such patients rapidly get fed up and may begin to act cruelly or neglectfully as a result of their feelings of inadequacy, thus hurting these patients when they are most needy and vulnerable. Treaters may fall into a similar pattern by becoming sarcastic or cold because their patients repeatedly reject their help.

The clinical vignette regarding Mr. L also underscores the importance of involving the family when treating a severely depressed patient. The literature on families of depressed patients clearly indicates that relapse rates, the course of depression, and suicidal behavior are all affected by family functioning (Keitner and Miller 1990). In one study (Hooley and Teasdale 1989), the single best predictor of relapse was the depressed patient's perception that his or her spouse was highly critical. Paralleling the research on families of schizophrenic patients, studies have also shown that high expressed emotion in family members of depressed patients may be influential in contributing to relapse (Hooley et al. 1986; Vaughn and Leff 1976). Depressed patients provoke a good deal of hostility and sadism in their family members, and clinicians must help relatives overcome their guilt feelings

about such reactions so that they can appreciate them as understandable responses to a depressed family member.

Indications and Contraindications

For many patients with depression or dysthymia, a combination of psychotherapy and medication appears optimal. Nemeroff (1998b) noted that whereas approximately 65% of depressed patients respond to a single antidepressant with a 50% decline on severity rating scales, only 30% return to a fully euthymic state based on their scores on such standard scales. Thase et al. (1997) found a highly significant advantage for combining psychotherapy and medication in the more severe recurrent depressions. However, when the milder forms of depression were studied, combined therapy was not more effective than psychotherapy alone. Medication is often ineffective in minor depression, and these patients may need psychotherapy to be restored to normal functioning.

Research is beginning to define certain forms of depression that may respond preferentially to psychotherapy. Nemeroff et al. (2003) studied chronic forms of major depression in association with childhood trauma. Six hundred eighty-one patients were treated with an antidepressant (nefazadone) alone, a form of cognitive psychotherapy alone, or a combination. Among those with a history of early childhood trauma, psychotherapy alone was superior to antidepressant monotherapy. In addition, the combination of pharmacotherapy and psychotherapy was only marginally superior to psychotherapy alone among the patients who had history of childhood abuse. Hence, the investigators concluded that psychotherapy may be an absolutely essential element in treating chronic forms of major depression where there is a history of childhood trauma.

Some depressed patients will not comply with their prescribed medication for a variety of reasons, including that they feel they do not deserve to get better or they feel that taking medication stigmatizes them as having a mental illness. de Jonge et al. (2001) concluded that combination treatment offered significant advantages compared with pharmacotherapy alone for patients with major depression. The patients in the combined group were significantly more compliant with medication and treatment in general and were therefore more likely to recover. One major advantage to combined treatment, then, is the ability to directly address noncompliance issues in a more effective and timely manner as part of the psychotherapeutic process.

Some patients adamantly refuse to take medications, cannot take medications due to preexisting medical conditions, or cannot tolerate side effects.

Psychodynamic approaches may be necessary to understand the meaning of medications and the reasons for refusal in such cases. Clinical experience has shown that some patients will accept medications after a preparatory phase of psychodynamic psychotherapy.

Other patients may have a condition that is partially or completely refractory to any somatic treatment. Long-term psychodynamic psychotherapy may be indicated in cases of treatment failures with multiple medication trials and/or brief therapies. Clinicians assessing these cases should have a high index of suspicion for three discrete categories (Gabbard 2000): 1) major depression comorbid with personality disorder, 2) depressive personality, and 3) characterological depression in the context of personality disorders. Regarding the first category, several studies (Duggan et al. 1991; Reich and Green 1991; Shea et al. 1990) have suggested that certain personality disorders may contribute to a tendency to maintain depression once it has already occurred, and characterological factors may also be responsible for poor medication compliance. Psychodynamic psychotherapy may be necessary in combination with medication to treat this population effectively.

With reference to the second category, much controversy has revolved around whether depressive personality disorder is truly distinct from dysthymia. Data suggest that the distinction between the two is valid and clinically useful (Phillips et al. 1998) and that the duration of psychotherapy is significantly longer for subjects who have depressive personality disorder than for those who do not. Dysthymic patients may also need combination treatment for optimal response. A trial of psychodynamic psychotherapy may be helpful in such cases to clarify diagnoses, define comorbidities, and promote recovery.

The third category refers primarily to patients with severe personality disorders, especially borderline, who complain of "depression" yet fail to meet DSM-5 (American Psychiatric Association 2013) criteria. These patients present unique treatment challenges for both the psychotherapist and the pharmacotherapist, and the American Psychiatric Association practice guidelines (American Psychiatric Association 2001) recommend combined treatment.

Treatment of the Suicidal Patient

Few events in a psychiatrist's professional life are more disturbing than a patient's suicide. In one study (Chemtob et al. 1988), approximately half of those psychiatrists who had lost a patient to suicide experienced stress levels comparable with that of persons recovering from a parent's death. Further research (Hendin et al. 2004) suggests that several specific factors may contrib-

ute to the distress that psychotherapists experience after the suicide of a patient. Of 34 therapists studied in the aftermath of a patient's suicide, 38% reported severe distress. Four key contributors to that distress were failure to hospitalize an imminently suicidal patient who subsequently died, making a treatment decision the therapist felt contributed to the suicide, having received negative reactions from the therapist's institution, and fearing a lawsuit by the patient's family. A completed suicide is a reminder of the limitations inherent in our craft. The natural tendency, whether in hospital practice or in psychotherapy, is for clinicians to go to great lengths to prevent suicide. To implement reasonable measures to prevent patients from taking their life is certainly good judgment from a clinical standpoint, responsible behavior from an ethical standpoint, and sound defensive medicine from a medicolegal standpoint. However, when the role of savior becomes all-consuming, the results may be countertherapeutic.

First, clinicians must always keep in mind one unassailable fact: patients who are truly intent on killing themselves will ultimately do so. No amount of physical restraint, careful observation, and clinical skill can stop the truly determined suicidal patient. One such patient was placed in a seclusion room with nothing but a mattress. All his clothing and possessions were taken away, and the patient was checked at regular 15-minute intervals around the clock. Between the 15-minute staff rounds, the patient began jumping on the mattress so hard that he was able to repeatedly bang his head against the ceiling until he finally broke his neck. Such incidents illustrate that hospital staff members must acknowledge to themselves that they cannot prevent all suicides from occurring on an inpatient unit. Olin (1976) has even suggested that if suicides never occur in a particular hospital, the staff members in the milieu may be taking too much responsibility for the behavior of the patients. Instead, clinicians should repeatedly stress that it is ultimately each patient's responsibility to learn to verbalize suicidal impulses rather than act on them.

After completed suicides, clinicians often feel guilty for not having detected warning signs that would have allowed them to predict an imminent suicide attempt. Despite an accumulating body of literature on short-term and long-range risk factors for suicide, our ability to predict the suicide of an individual patient is still severely limited. Goldstein et al. (1991) studied a group of 1,906 inpatients with affective disorders. Using data on risk factors, the researchers applied stepwise multiple logistic regression to develop a statistical model that would successfully predict suicide. This model failed to identify a single patient who committed suicide. The investigators reluctantly concluded that even among a high-risk group of inpatients, predicting suicide based on our current understanding of the phenomenon is not possible. The primary means of assessing imminent suicide risk in a clinical set-

ting is the verbal communication of intent by a patient or an action that is clearly suicidal in intent. Clinicians cannot read minds and must not berate themselves for their perceived failures when no clear verbal or nonverbal indications of suicidality were present. One study (Isometsä et al. 1995) found that of 571 cases of suicide, only 36% of those in psychiatric care communicated suicidal intent.

Treatment of suicidal depression ordinarily includes optimal pharmacotherapy or ECT. Several risk factors should be assessed, including the following: feelings of hopelessness, severe anxiety or panic attacks, substance abuse, recent adverse events, financial problems or unemployment, living alone, being widowed or divorced, male sex, and an age of 60 years or older (Clark and Fawcett 1992; Hirschfeld and Russell 1997). If the patient has a definite plan and appears to be intent on taking immediate action, emergency psychiatric hospitalization is required. If the risk of suicide is substantial but not imminent, a family member or other close person should be involved. The availability of firearms in the home or elsewhere should be assessed. Literature reviews (Cummings and Koepsell 1998; Miller and Hemenway 1999) provide strong evidence that the availability of a gun increases the risk of suicide to a substantial degree. Regular communication is essential in such circumstances, and substance abuse must be investigated as well. In cases of intense anxiety or panic, the use of a benzodiazepine should be considered (Hirschfeld and Russell 1997). Psychotherapy may also be of extraordinary importance in understanding why the patient wants to die and what he or she expects will happen following death.

Suicide risk with any patient is a formidable challenge. Many patients will deny any of the risk factors because they do not want to be stopped from killing themselves. However, recently, an implicit association test has been developed that provides some empirical data based on the unconscious associations of the patient. The individual is asked to classify stimuli representing the constructs of "death," "life," and "me" versus "not me." The implicit association of death or suicide with the self was associated with an approximately sixfold increase in the odds of making a suicide attempt in the next 6 months (Nock et al. 2010). The investigators clarified that this exceeds the predictive validity of known risk factors.

Psychodynamic clinicians tend to agree that treaters who fall prey to the illusion that they can save their patients from suicide are actually decreasing their chances of doing so (Hendin 1982; Meissner 1986; Richman and Eyman 1990; Searles 1967/1979; Zee 1972). One salient psychological concern in the seriously suicidal patient is the desire to be taken care of by an unconditionally loving mother (Richman and Eyman 1990; Smith and Eyman 1988). Some therapists err in attempting to gratify this fantasy by meeting the patient's every need. They may accept phone calls from the patient any

time of the day or night and throughout their vacations. They may see the patient 7 days a week in their office. Some have even become sexually involved with their patients in a desperate effort to gratify the unending demands associated with the depression (Twemlow and Gabbard 1989). This kind of behavior exacerbates what Hendin (1982) described as one of the most lethal features of suicidal patients—namely, their tendency to assign others the responsibility for their staying alive. By attempting to gratify these ever escalating demands, the therapist colludes with the patient's fantasy that there really is an unconditionally loving mother out there somewhere who is different from everyone else. Therapists cannot possibly sustain that illusion indefinitely; those who attempt to do so are setting up the patient for a crushing disappointment that may increase the risk of suicide.

Clinicians who are drawn into the role of savior with suicidal patients often operate on the conscious or unconscious assumption that they can provide the love and concern that others have not, thus magically transforming the patient's wish to die into a desire to live. This fantasy is a trap, however, because, as Hendin (1982) noted, "The patient's hidden agenda is an attempt to prove that nothing the therapist can do will be enough. The therapist's wish to see himself as the suicidal patient's savior may blind the therapist to the fact that the patient has cast him in the role of executioner" (pp. 171–172). Therapists are more useful to suicidal patients when they diligently try to understand and analyze the origin of the suicidal wishes instead of placing themselves in bondage to the patient.

Therapists should be on the lookout for idealizing transferences, which often form rapidly when patients are looking for a rescuer. Predicting and interpreting transference disappointments early in the process may be helpful. Some therapists openly acknowledge that they cannot stop the patient from committing suicide and offer instead the opportunity to understand why the patient thinks that suicide is the only option (Henseler 1991). Often this admission has a calming effect and may produce greater collaboration in the psychotherapeutic task.

It is useful to distinguish between *treatment* and *management* of the suicidal patient. The latter includes measures such as continuous observation, physical restraints, and removal of sharp objects from the environment. Although these interventions are useful in preventing the patient from acting on suicidal urges, management techniques do not necessarily decrease a patient's future vulnerability to resorting to suicidal behavior. *Treatment* of suicidal patients—consisting of medication and a psychotherapeutic approach to understanding the internal factors and external stressors that make the patient suicidal—is needed to alter the fundamental wish to die.

The countertransference elicited by the suicidal patient presents a formidable obstacle to treatment. Some clinicians simply avoid any responsibility

for seriously depressed patients who are at risk for killing themselves. Those who do attempt to treat such patients often believe that their *raison d'être* is negated by the patient's wish to die. A patient's suicide is also the ultimate narcissistic injury for the treater. Clinicians' anxiety about the suicide of the patient may stem more from the fear that others will blame them for the death than from concern for the individual patient's welfare (Hendin 1982; Hendin et al. 2004). It is commonplace for therapists to set one standard for others and another for themselves. The therapist who assures other clinicians that he or she is not responsible for a patient's suicide may feel an exaggerated sense of responsibility for keeping his or her own patients alive, often with the assumption that other therapists will be critical if a patient dies.

Therapists who treat seriously suicidal patients will eventually begin to feel tormented by the repeated negation of their efforts. Countertransference hate is likely to develop at such times, and treaters will often harbor an unconscious wish for the patient to die so that the torment will end. Maltsberger and Buie (1974) noted that feelings of malice and aversion are among the most common countertransference reactions connected with the treatment of severely suicidal patients. The inability to tolerate their own sadistic wishes toward such patients may lead treaters to act out countertransference feelings. The authors caution that although malice may be more unacceptable and uncomfortable, aversion is potentially more lethal because it can lead clinicians to neglect their patients and provide an opportunity for a suicide attempt. On an inpatient unit, this form of countertransference may be manifested by simply "forgetting" to check on the patient as dictated by the suicidal observation order.

Countertransference hatred must be accepted as part of the experience of treating suicidal patients. It often arises in direct response to the patient's aggression. Suicide threats may be held over the therapist's head like the mythical sword of Damocles, tormenting and controlling the therapist night and day. Similarly, the family members of patients may be plagued with the concerns that if they make one false move or one unempathic comment, they will be responsible for a suicide. If countertransference hate is split off and disavowed by the therapist, it may be projected onto the patient, who then must deal with the therapist's murderous wishes in addition to the preexisting suicidal impulses. Clinicians may also deal with their feelings of aggression by reaction formation, which may lead to rescue fantasies and exaggerated efforts to prevent suicide. Searles (1967/1979) warned therapists of the perils of this defensive style:

> And the suicidal patient, who finds us so unable to be aware of the murderous feelings he fosters in us through his guilt- and anxiety-producing threats of suicide, feels increasingly constricted, perhaps indeed to the point of sui-

> cide, by the therapist who, in reaction formation against his intensifying, unconscious wishes to kill the patient, hovers increasingly "protectively" about the latter, for whom he feels an omnipotence-based physicianly concern. Hence, it is, paradoxically, the very physician most anxiously concerned to *keep the patient alive* who tends most vigorously, at an unconscious level, to drive him to what has come to seem the only autonomous act left to him—namely, suicide. (p. 74)

Psychotherapists who treat suicidal patients must help them come to terms with their dominant ideology (Arieti 1977) and their rigidly held life fantasies (Richman and Eyman 1990; Smith and Eyman 1988). When there is a disparity between reality and the patient's constricted view of what life should be like, the therapist can help the patient mourn the loss of the life fantasy. This technique may paradoxically require the therapist to acknowledge the patient's hopelessness so that the lost dreams can be mourned and replaced by new ones that are more realistic. For example, one 23-year-old man became suicidal when he realized that he would never be accepted to Harvard, a dream he had cherished since early childhood. The therapist acknowledged that admission to Harvard was highly unlikely and then helped the patient accept the loss of that dream. At the same time, he helped the patient consider alternative pathways to an education that would build the patient's self-esteem. Thus the therapist helped the patient see how much misery is caused by unrealistically high expectations (Richman and Eyman 1990).

To treat suicidal patients effectively, clinicians must distinguish the patient's responsibility from the treater's responsibility. Physicians in general and psychiatrists in particular are characterologically prone to an exaggerated sense of responsibility (Gabbard 1985). In this regard it is useful to give a portion of the responsibility for staying safe to the patient. A contract that the patient signs indicating he or she will not commit suicide has no legal standing and is rarely of any clinical value. An alternative is a safety plan jointly constructed by therapist and patient (Stanley et al. 2009). This plan provides the patient with a specific set of coping strategies and sources of support when suicidal thoughts emerge. The plan's perspective is based on the recognition that suicidal urges ebb and flow rather than remain constant. The safety plan also operates on the assumption that patients are not simply at the mercy of their suicidal feelings—they can develop a plan of coping with the feelings that avoids a regular trip to the emergency room.

Within this model, the patient must recognize warning signs that suicidality has returned and then automatically implement a series of steps that have been collaboratively developed with the therapist. These may include socializing with specific family members or friends; removing any item in the home that might be used for a suicide attempt; involving oneself in activities, such as exercise or cleaning up one's office or house, that will dis-

tract one's thinking; or playing games or doing Internet searches that one finds gratifying.

Therapists, on the other hand, must balance concern for the patient with calmness and must not be overly anxious. A matter-of-factness is essential. There needs to be a tolerance developed for suicidality because the patient will be less anxious if the therapist is calm. Finally, the therapist must do his or her part in the collaborative plan.

We tend to blame ourselves for adverse outcomes beyond our control. Ultimately, we must reconcile ourselves to the fact that there are terminal psychiatric illnesses. Patients must bear the responsibility for deciding whether they will commit suicide or work collaboratively with their therapist to understand the wish to die. Fortunately, the vast majority of patients contemplate suicide with some ambivalence. The part of the suicidal individual that questions the suicidal solution may lead these patients to choose life over death.

References

Abraham K: A short study of the development of the libido, viewed in light of mental disorders (1924), in Selected Papers on Psychoanalysis. London, Hogarth, 1927, pp 418–501

Agid O, Shapiro B, Zislan J, et al: Environment and vulnerability to major psychiatric illness: a case control study of early parental loss in major depression, bipolar disorder, and schizophrenia. Mol Psychiatry 4:163–172, 1999

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

American Psychiatric Association: Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. Washington, DC, American Psychiatric Association, 2001

Arieti S: Psychotherapy of severe depression. Am J Psychiatry 134:864–868, 1977

Asch SS: Suicide and the hidden executioner. International Review of Psychoanalysis 7:51–60, 1980

Bebbington PE, Cooper C, Minot S, et al: Suicide attempts, gender, and sexual abuse: data from the 2000 British Psychiatric Morbidity Survey. Am J Psychiatry 166:1135–1140, 2009

Bernet CZ, Stein MB: Relationship of childhood maltreatment to the onset and course of major depression in adulthood. Depress Anxiety 9:169–174, 1999

Betcher RW: The treatment of depression in brief inpatient group psychotherapy. Int J Group Psychother 33:365–385, 1983

Bibring E: The mechanism of depression, in Affective Disorders: Psychoanalytic Contributions to Their Study. Edited by Greenacre P. New York, International Universities Press, 1953, pp 13–48

Bifulco A, Brown GW, Moran P, et al: Predicting depression in women: the role of past and present vulnerability. Psychol Med 28:39–50, 1998

Blakely RD, Veenstra-VanderWeele J: Genetic indeterminism, the 5-HTTLPR, and the paths forward in neuropsychiatric genetics. Arch Gen Psychiatry 68:457–458, 2011

Blatt SJ: The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patients: the Menninger Psychotherapy Research Project revisited. J Am Psychoanal Assoc 40:691–724, 1992

Blatt SJ: Contributions of psychoanalysis to the understanding and treatment of depression. J Am Psychoanal Assoc 46:723–752, 1998

Blatt SJ: Experiences of Depression: Theoretical, Clinical and Research Perspectives. Washington, DC, American Psychological Association, 2004

Blatt SJ, Ford R, Berman WH, et al: Therapeutic Change: An Object Relations Perspective. New York, Plenum, 1994

Blatt SJ, Quinlan DM, Pilkonis PA, et al: Impact of perfectionism and the need for approval in the brief treatment of depression: the National Institute of Mental Health Treatment of Depression Collaborative Research Program revised. J Consult Clin Psychol 63:125–132, 1995

Bowlby J: Attachment and Loss, Vol 1: Attachment. New York, Basic Books, 1969

Bradley RG, Binder EB, Epstein MP, et al: Influence of child abuse on adult depression: moderation by the corticotropin-releasing hormone receptor gene. Arch Gen Psychiatry 65:190–200, 2008

Brown G: Life events and affective disorder: replications and limitations. Psychosom Med 55:248–259, 1993

Brown G, Eales M: Etiology of anxiety and depressive disorders in an inner-city population. Psychol Med 23:155–165, 1993

Brzustowicz L, Freedman R: Digging more deeply for genetic effects in psychiatric illness. Am J Psychiatry 168:1017–1020, 2011

Bunch J, Barraclough B: The influence of parental death and anniversaries upon suicide dates. Br J Psychiatry 118:621–626, 1971

Burnand Y, Andreoli A, Kolatte E et al: Psychodynamic psychotherapy and clomipramine in the treatment of depression. Psychiatr Serv 53:585–590, 2002

Busch FN, Rudden M, Shapiro T: Psychodynamic Treatment of Depression. Washington, DC, American Psychiatric Publishing, 2004

Caspi A, Sugden K, Moffitt TE, et al: Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science 301:386–389, 2003

Chemtob CM, Hamada RS, Bauer G, et al: Patients' suicides: frequency and impact on psychiatrists. Am J Psychiatry 145:224–228, 1988

Clark DC, Fawcett J: An empirically based model of suicide risk assessment for patients with affective disorder, in Suicide and Clinical Practice. Edited by Jacobs D. Washington, DC, American Psychiatric Press, 1992, pp 55–73

Cuijpers P, van Straten A, Andersson G, et al: Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. J Consult Clin Psychol 76:909–922, 2008

Cummings P, Koepsell TD: Does owning a firearm increase or decrease the risk of death? JAMA 280:471–473, 1998

de Jonghe F, Kool S, van Aalst G, et al: Combining psychotherapy and antidepressants in the treatment of depression. J Affect Disord 64:217–229, 2001

Dorpat TL: Suicide, loss, and mourning. Suicide Life Threat Behav 3:213–224, 1973

Driessen E, Cuijpers P, de Maat SCM, et al: The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis. Clin Psychol Rev 30:25–36, 2010

Driessen E, Van HL, Don FJ, et al: The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. Am J Psychiatry 170:1041–1050, 2013

Duggan CF, Lee AS, Murray RM: Do different subtypes of hospitalized depressives have different long-term outcomes? Arch Gen Psychiatry 48:308–312, 1991

Dumais A, Lesage AD, Alda M: Risk factors for suicide completion in major depression: a case-control study of impulsive and aggressive behaviors in men. Am J Psychiatry 162:2116–2124, 2005

Ellicott A, Hammen C, Gitlin M, et al: Life events and the course of bipolar disorder. Am J Psychiatry 147:1194–1198, 1990

Fenichel O: The Psychoanalytic Theory of Neurosis. New York, WW Norton, 1945

Freud S: The ego and the id (1923), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 19. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 1–66

Freud S: Mourning and melancholia (1917), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 14. Translated and edited by Strachey J. London, Hogarth Press, 1963, pp 237–260

Gabbard GO: The role of compulsiveness in the normal physician. JAMA 254:2926–2929, 1985

Gabbard GO: Psychodynamic Psychotherapy in Clinical Practice, 3rd Edition. Washington, DC, American Psychiatric Press, 2000

Ghaemi SN, Stoll SL, Pope HG: Lack of insight in bipolar disorder: the acute manic episode. J Nerv Ment Dis 183:464–467, 1995

Gibbons MBC, Thompson SM, Scott K, et al: Supportive-expressive dynamic psychotherapy in the community mental health system: a pilot effectiveness trial for the treatment of depression. Psychotherapy 49:303–316, 2012

Gilman SE, Kawachi I, Fitzmaurice GM, et al: Family disruption in childhood and risk of adult depression. Am J Psychiatry 160:939–946, 2003

Goldstein RB, Black DW, Nasrallah A, et al: The prediction of suicide: sensitivity, specificity, and predictive value of a multimyriad model applied to suicide among 1,906 patients with affective disorders. Arch Gen Psychiatry 48:418–422, 1991

Gotlib IH, Joormann J, Minor KL, et al: HPA axis reactivity: a mechanism underlying the associations among 5-HTTLPR, stress, and depression. Biol Psychiatry 63:847–851, 2008

Hammen CL: Stress and the course of unipolar and bipolar disorders, in Does Stress Cause Psychiatric Illness? Edited by Mazure CM. Washington, DC, American Psychiatric Press, 1995, pp 87–110

Hammen C, Marks T, Mayol A, et al: Depressive self-schemas, life stress, and vulnerability to depression. J Abnorm Psychol 94:308–319, 1985

Hammen C, Henry R, Daley S: Depression and sensitization to stressors among young women as a function of childhood adversity. J Consult Clin Psychol 68: 782–787, 2000

Hayes AM, Castonguay LG, Goldfried MR: Effectiveness of targeting vulnerability factors of depression in cognitive therapy. J Consult Clin Psychol 64:623–627, 1996

Heim C, Newport DJ, Heit S, et al: Pituitary-adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood. JAMA 284:592–597, 2000

Hendin H: Psychotherapy and suicide, in Suicide in America. New York, WW Norton, 1982, pp 160–174

Hendin H, Haas AP, Maltsberger JT: Factors contributing to therapists' distress after the suicide of a patient. Am J Psychiatry 161:1442–1446, 2004

Henseler H: Narcissism as a form of relationship, in Freud's On Narcissism: An Introduction. Edited by Sandler J, Person ES, Fonagy P. New Haven, CT, Yale University Press, 1991, pp 195–215

Hewitt PL, Newton J, Flett GL, et al: Perfectionism and suicide ideation in adolescent psychiatric patients. J Abnorm Child Psychol 25:95–101, 1997

Hilsenroth MJ, Ackerman SJ, Blagys MD, et al: Short-term psychodynamic psychotherapy for depression: an examination of statistical, clinically significant, and technique-specific change. J Nerv Ment Dis 191:349–357, 2003

Hirschfeld RMA, Russell JM: Assessment and treatment of suicidal patients. N Engl J Med 337:910–915, 1997

Hooley JM, Teasdale JD: Predictors of relapse in unipolar depressives: expressed emotion, marital distress, and perceived criticism. J Abnorm Psychol 98:229–235, 1989

Hooley JM, Orley J, Teasdale JD: Levels of expressed emotion and relapse in depressed patients. Br J Psychiatry 148:642–647, 1986

Isometsä ET, Heikkinen ME, Marttunen MJ, et al: The last appointment before suicide: is suicide intent communicated? Am J Psychiatry 152:919–922, 1995

Jacobson E: Psychotic identifications, in Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions. Edited by Jacobson E. New York, International Universities Press, 1971a, pp 242–263

Jacobson E: Transference problems in depressives, in Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions. Edited by Jacobson E. New York, International Universities Press, 1971b, pp 284–301

Jamison KR: An Unquiet Mind. New York, Vintage Books, 1995

Jones EE, Pulos SM: Comparing the process of psychodynamic and cognitive behavioral therapies. J Consult Clin Psychol 61:306–316, 1993

Keitner GI, Miller IW: Family functioning and major depression: an overview. Am J Psychiatry 147:1128–1137, 1990

Kendler KS, Neale MC, Kessler RC, et al: Childhood parental loss and adult psychopathology in women: a twin study perspective. Arch Gen Psychiatry 49:109–116, 1992

Kendler KS, Kessler RC, Neale MC: The prediction of major depression in women: toward an integrated etiological model. Am J Psychiatry 150:1139–1148, 1993

Kendler KS, Kessler RC, Walters EE, et al: Stressful life events, genetic liability, and onset of an episode of major depression in women. Am J Psychiatry 152:833–842, 1995

Kendler KS, Karkowski LM, Prescott CA: Causal relationship between stressful life events and the onset of major depression. Am J Psychiatry 156:837–841, 1999

Kendler KS, Thornton LM, Prescott CA: Gender differences in the rates of exposure to stressful life events and sensitivity to their depressogenic effects. Am J Psychiatry 158:587–593, 2001

Kendler KS, Hettema JM, Butera F, et al: Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. Arch Gen Psychiatry 60:789–796, 2003

Kendler KS, Myers J, Zisook S: Does bereavement-related major depression differ from major depression associated with other stressful life events? Am J Psychiatry 165:1449–1455, 2008

Klein M: Mourning and its relation to manic-depressive states (1940), in Love, Guilt and Reparation and Other Works 1921–1945. New York, Free Press, 1975, pp 344–369

Kwon P: Attributional style and psychodynamic defense mechanisms: toward an integrative model of depression. J Pers 67:645–658, 1999

Kwon P, Lemmon KE: Attributional style and defense mechanisms: a synthesis of cognitive and psychodynamic factors in depression. J Clin Psychol 56:723–735, 2000

Lesse S: Psychotherapy in combination with antidepressant drugs in severely depressed outpatients: 20-year evaluation. Am J Psychother 32:48–73, 1978

Levitan RD, Parikh SV, Lesage AD, et al: Major depression in individuals with a history of childhood physical or sexual abuse: relationship to neurovegetative features, mania and gender. Am J Psychiatry 155:1746–1752, 1998

Maj M: Lithium prophylaxis of bipolar disorder in ordinary clinical conditions: patterns of long-term outcome, in Bipolar Disorders: Clinical Course and Outcome. Edited by Goldberg JF, Harrow M. Washington, DC, American Psychiatric Press, 1999, pp 21–37

Maltsberger JT, Buie DH: Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry 30:625–633, 1974

Maxmen JS: An educative model for inpatient group therapy. Int J Group Psychother 28:321–338, 1978

Meissner WW: Psychotherapy and the Paranoid Process. Northvale, NJ, Jason Aronson, 1986

Menninger KA: Psychoanalytic aspects of suicide. Int J Psychoanal 14:376–390, 1933

Miklowitz DJ: Adjunctive psychotherapy for bipolar disorder: state of the evidence. Am J Psychiatry 165:1408–1419, 2008

Miklowitz DJ, Frank E: New psychotherapies for bipolar disorder, in Bipolar Disorders: Clinical Course and Outcome. Edited by Goldberg JF, Harrow M. Washington, DC, American Psychiatric Press, 1999, pp 57–84

Miklowitz DJ, George EL, Richards JA, et al: A randomized study of family focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. Arch Gen Psychiatry 60:904–912, 2003

Miller M, Hemenway D: The relationship between firearms and suicide: a review of the literature. Aggress Violent Behav 4:59–75, 1999

Mortensen PB, Pedersen CB, Melbye M, et al: Individual and familial risk factors for bipolar affective disorders in Denmark. Arch Gen Psychiatry 60:1209–1215, 2003

Nemeroff CB: The neurobiology of depression. Sci Am 278:42–49, 1998a

Nemeroff CB: Polypharmacology in psychiatry: good or bad? CNS Spectrums 3:19, 1998b

Nemeroff C: The pre-eminent role of early untoward experience on vulnerability to major psychiatric disorders: the nature-nurture controversy revisited and soon to be resolved. Mol Psychiatry 4:106–108, 1999

Nemeroff C: The neurobiological consequences of child abuse. Presentation at the 156th annual meeting of the American Psychiatric Association, San Francisco, CA, May 17–22, 2003

Nemeroff CB, Heim CM, Thase ME, et al: Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. Proc Natl Acad Sci U S A 100:14,293–14,296, 2003

Nock MK, Park JM, Finn CT, et al: Measuring the suicidal mind: implicit cognition predicts suicidal behavior. Psychol Sci 21:511–517, 2010

Olin HS: Psychotherapy of the chronically suicidal patient. Am J Psychother 30:570–575, 1976

Phillips KA, Gunderson JG, Triebwasser J, et al: Reliability and validity of depressive personality disorder. Am J Psychiatry 155:1044–1048, 1998

Post RM, Rubinow ER, Uhde TW, et al: Dysphoric mania: clinical and biological correlates. Arch Gen Psychiatry 46:353–358, 1989

Reich JH, Green AI: Effect of personality disorders on outcome of treatment. J Nerv Ment Dis 179:74–82, 1991

Richman J, Eyman JR: Psychotherapy of suicide: individual, group, and family approaches, in Understanding Suicide: The State of the Art. Edited by Lester D. Philadelphia, PA, Charles C Thomas, 1990, pp 139–158

Salminen JK, Karlsson H, Hietala J, et al: Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: a randomized comparative study. Psychother Psychosom 77:351–357, 2008

Salzman C: Integrating pharmacotherapy and psychotherapy in the treatment of a bipolar patient. Am J Psychiatry 155:686–688, 1998

Sandler J, Joffe WG: Notes on childhood depression, Int J Psychoanal 46:88–96, 1965

Sareen J, Cox BJ, Afifi TO, et al: Anxiety disorders and risk for suicidal ideation and suicide attempts. Arch Gen Psychiatry 62:1249–1257, 2005

Searles HF: The "dedicated physician" in the field of psychotherapy and psychoanalysis (1967), in Countertransference and Related Subjects. Madison, CT, International Universities Press, 1979, pp 71–88

Shea MT, Pilkonis PA, Beckham E, et al: Personality disorders and treatment outcome in the NIMH Treatment of Depression Collaborative Research Program. Am J Psychiatry 147:711–718, 1990

Smith K: Using a battery of tests to predict suicide in a long term hospital: a clinical analysis. Omega 13:261–275, 1983

Smith K, Eyman J: Ego structure and object differentiation in suicidal patients, in Primitive Mental States of the Rorschach. Edited by Lerner HD, Lerner PM. Madison, CT, International Universities Press, 1988, pp 175–202

Stanley B, Brown G, Brent D, et al: Cognitive behavior therapy for suicide prevention (CBT-SP): treatment model, feasibility and acceptability. J Am Acad Child Adolesc Psychiatry 48:1005–1013, 2009

Stroebe M, Stroebe W, Abakoumkin G: The broken heart: suicidal ideation in bereavement. Am J Psychiatry 162:2178–2180, 2005

Thase ME, Greenhouse JB, Frank E, et al: Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. Arch Gen Psychiatry 54:1009–1015, 1997

Twemlow SW, Gabbard GO: The lovesick therapist, in Sexual Exploitation in Professional Relationships. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1989, pp 71–87

Vaillant GE, Vaillant CA: A cross-validation of two methods of investigating defenses, in Ego Mechanisms of Defense: A Guide for Clinicians and Researchers. Edited by Vaillant GE. Washington, DC, American Psychiatric Press, 1992, pp 159–170

Vaughn CE, Leff JP: The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic patients and neurotic patients. Br J Psychiatry 129:125–137, 1976

Vythilingam M, Heim C, Newport J, et al: Childhood trauma associated with smaller hippocampal volume in women with major depression. Am J Psychiatry 159: 2072–2080, 2002

Zee HJ: Blindspots in recognizing serious suicidal intentions. Bull Menninger Clin 36:551–555, 1972

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CHAPTER 9

ANXIETY DISORDERS

> As a rule, what is out of sight disturbs men's minds more seriously than what they see.
>
> *Julius Caesar*

Anxiety is an affect that was instrumental in the birth of psychoanalysis and psychodynamic psychiatry. Freud (1895/1962) coined the term *anxiety neurosis* and identified two forms of anxiety. One form was the diffuse sense of worry or dread that originated in a repressed thought or wish and was curable through psychotherapeutic intervention. The second form of anxiety was characterized by an overwhelming sense of panic, accompanied by manifestations of autonomic discharge, including profuse sweating, increased respiratory and heart rates, diarrhea, and a subjective sense of terror. This latter form, in Freud's view, did not result from psychological factors. Rather, it was conceptualized as the result of the physiological buildup of libido related to a lack of sexual activity. He referred to this form as *actual neurosis*.

By 1926 Freud had further refined his understanding of anxiety as a result of his recent creation, the structural model (Freud 1926/1959). Anxiety was now viewed as the result of psychic conflict between unconscious sexual or aggressive wishes stemming from the id and corresponding threats of punishment from the superego. Anxiety was understood as a *signal* of the

presence of danger in the unconscious. In response to this signal, the ego mobilized defense mechanisms to prevent unacceptable thoughts and feelings from emerging into conscious awareness. If signal anxiety failed to adequately activate the ego's defensive resources, then intense, more persistent anxiety or other neurotic symptoms would result. In this sense, anxiety was conceptualized by Freud as both a symptomatic manifestation of neurotic conflict and an adaptive signal to ward off awareness of neurotic conflict.

In Freud's model, anxiety is an ego affect. The ego controls access to consciousness and, through repression, divorces itself from any association with instinctual impulses from the id. It censors both the impulse itself and the corresponding intrapsychic representation. A repressed instinctual wish or impulse may still find expression as a symptom, although it is likely to be displaced and disguised by the time it reaches symptomatic expression. Depending on the defensive operations and symptomatic manifestations, the resulting neurosis might take the form of an obsessional thought, a hysterical paralysis, or a phobic avoidance.

Anxiety may be attached to a conscious, acceptable fear that masks a deeper, less acceptable concern. Some patients may present with anxiety but have absolutely no idea why they are anxious. The task of the psychodynamic clinician is to understand the unconscious origins of such anxiety. Freud originated the idea that each successive developmental period in a child's life produces a characteristic fear associated with that phase. From Freud's discoveries and those of subsequent psychoanalytic investigators, a developmental hierarchy of anxiety (Table 9–1) can be constructed to assist the psychodynamic clinician in determining the unconscious sources of a patient's symptomatic anxiety.

At the most mature level, anxiety originating in the superego can be understood as guilt feelings or pangs of conscience about not living up to an internal standard of moral behavior. During the oedipal phase, anxiety focuses on potential damage to or loss of the genitals at the hands of a retaliatory parental figure. This fear may be expressed metaphorically as loss of another body part or any other form of physical injury. Moving back in the developmental hierarchy to a somewhat earlier anxiety, we find the fear of losing the love or approval of a significant other (originally a parent). A developmentally more primitive source of anxiety is the possibility of losing not just the object's love but also the object itself—what is usually referred to as *separation anxiety.* The most primitive forms of anxiety are *persecutory anxiety* and *disintegration anxiety.* The former derives from the Kleinian paranoid-schizoid position, in which the primary anxiety is that persecuting objects from outside will invade and annihilate the patient from within. Disintegration anxiety may derive either from the fear of losing one's sense of self or boundedness through merger with an object or from concern that

TABLE 9–1. A developmental hierarchy of anxiety

Superego anxiety
Castration anxiety
Fear of loss of love
Fear of loss of the object (separation anxiety)
Persecutory anxiety
Disintegration anxiety

one's self will fragment and lose its integrity in the absence of mirroring or idealizing responses from others in the environment.

Whenever anxiety forms part of the clinical picture, the psychodynamic psychiatrist must enlist the patient's collaboration in identifying the developmental origins of the anxiety. This information may be ascertained within a 1-hour interview, or it may take an extensive evaluation. Anxiety, like most symptoms, is often multiply determined by issues deriving from a variety of developmental levels (Gabbard and Nemiah 1985).

The hierarchical organization of these variants of anxiety may lead to the mistaken assumption that more primitive levels of anxiety are "outgrown" as development proceeds. In fact, the most primitive levels of anxiety persist in everyone and can be easily triggered in traumatic or stressful situations or in large groups. For example, persecutory anxieties about "outsiders" or those who are different have historically been major factors in wars, geographical and political tensions, and racial prejudice. This developmental hierarchy is only a guideline to assist the clinician. Each person will have a unique blend of anxieties, and some may have anxieties that do not neatly fit into these categories. The clinician must be creative in understanding each patient's specific fears and the origins of those fears.

Empirical evidence links biological and genetic factors to the generation of anxiety. Although the advances in neuroscience research on anxiety disorders have been impressive, there is nonetheless a risk of a kind of biological reductionism in understanding anxiety. Neurophysiological mechanisms may produce an adaptive form of signal anxiety as well as the more pathological forms of chronic symptomatic anxiety.

As noted in Chapter 1, polymorphisms in the serotonin transporter gene (5-*HTTLPR*) have been studied with great interest in both depression and posttraumatic stress disorder. Research has also revealed possible contributions of this gene to the development of anxiety. Lesch et al. (1996) found that individuals with a somewhat shorter version of the gene may have greater anxiety associated with a neuroticism temperament than those who have a longer version of the gene. In addition, those individuals who have

one or two copies of the short allele exhibit greater amygdalar neuronal activity in response to fearful stimuli when compared with individuals who have a longer version (Hariri et al. 2002). Nearly 70% of people have the shorter and less vigorous version of the gene that is associated with greater anxiety. One interpretation of this finding is that this distribution may well reflect natural selection, in that individuals with greater anxiety might be better equipped to survive dangers in their environment than those who are less worried or concerned.

A twin study designed to examine genetic and environmental risk factors for anxiety disorders (Hettema et al. 2005) found that genes predisposed to two broad groups of disorders, one related to panic and generalized anxiety and another linked to specific phobias. The other associations between the disorders tend to be related to environmental factors. Another twin study (Kendler et al. 2008) found that fear-proneness involved developmentally dynamic effects, with genetic factors influencing fear intensity at ages 8–9 but declining substantially in importance over time. New sets of genetic risk factors impact fear intensity in early adolescence, late adolescence, and early adulthood. As children age, familial and environmental influences of peers appear to decline in importance. In literature, film, and popular culture, anxiety is often trivialized. However, a population-based longitudinal study of adults found that a preexisting anxiety disorder is an independent risk factor for subsequent onset of suicidal ideation and attempts (Sareen et al. 2005). In addition, as noted in Chapter 8, intense anxiety can amplify the risk of suicide attempts in persons with mood disorders. The diagnosis and treatment of anxiety disorders must be taken seriously as part of a thorough psychiatric assessment.

By categorizing anxiety as an illness rather than also viewing it as an overdetermined symptom of unconscious conflict, one may overlook this adaptive aspect of anxiety. Worrying about what will happen in the future can lead to highly creative thinking. Solutions to problems are found as a result of worry. Healthy self-doubt may also be linked to worrying. If anxiety is seen exclusively as a problem that must be eradicated psychopharmacologically, the human psyche may suffer a substantial loss.

In The Menninger Foundation Psychotherapy Research Project, 18 of 35 patients showed increased anxiety at the termination of psychoanalysis or psychotherapy, even though 13 of these 18 patients were judged by independent raters to have achieved substantial improvement (Appelbaum 1977). In evaluating these results, the investigators (Appelbaum 1977; Siegal and Rosen 1962) differentiated between primary anxiety, which is disorganizing to the patient (analogous to panic disorder), and signal anxiety, which may be adaptive. The researchers noted that an increase in anxiety tolerance—defined as the capacity to experience anxiety without having to discharge it—often oc-

curs as a result of dynamic psychotherapy and reflects expansion of the ego. Many of the improved patients showed striking improvements in their capacity to make efficient use of ideational activity in the service of binding anxiety. The investigators concluded that the mere presence or absence of anxiety after treatment was an insufficient basis for assessing change. It may well be that greater ego mastery over anxiety allows one to confront certain existential concerns inherent in life in a more forthright manner. Anxiety can be adaptive or maladaptive, and the assumption that all anxiety should be eradicated is certainly unwarranted based on clinical and life experience.

The psychoanalytic concept of signal anxiety is supported by neuroscientific evidence from research into a subset of unconscious mental processes that have a signal function of anticipating danger (Wong 1999). Brain activity (event-related potential) and electrodermal activity were measured as participants in this research viewed subliminal (unconscious) images of a face. A second phase of the experiment involved conditioning, in which supraliminal (conscious) presentations of an unpleasant face were linked to an aversive finger shock. Because the face was consciously perceived, the subjects learned that a mild shock would follow several seconds after seeing the unpleasant face. In the final phase of the experiment, subliminal (unconscious) images of the previously conditioned stimuli—the unpleasant face—were presented without link to a shock. In this final phase, distinct slow-wave brain activity occurred just before the point at which the shock had been delivered previously. No activity was found for a pleasant face. The investigators noted that this slow-wave brain activity was an expectancy wave or anticipatory process that was elicited unconsciously. In other words, even though there was no conscious perception of the unpleasant face, unconsciously the stimulus was perceived and the brain reacted with the expectation of a shock. This physiological reactivity was understood as an index of mental processes such as expectation. This demonstration that an anticipatory mental state can be elicited unconsciously in humans provides a critical piece of evidence consistent with the signal concept. The research also reflects the fact that some anxiety may initially be unconscious in response to an anticipated feared situation and may only gradually enter into conscious awareness. Anxiety in this way serves an adaptive function to warn the individual about a danger situation that can then be handled in a way that may avoid the danger.

One final problem should be mentioned by way of introducing the DSM-5 (American Psychiatric Association 2013) anxiety disorders. There is a growing concern among researchers and clinicians that the taxonomy associated with anxiety disorders is more illusory than real (Tyrer et al. 2003). Comorbidity studies of anxiety disorders are finding that patients are more likely to have two or more anxiety disorders than a pure form of any of the specific diagnostic entities. Hence, a clinician developing a comprehensive

treatment plan must keep in mind that more than one anxiety disorder is likely to be the focus of treatment. Moreover, Tyrer et al. (2003) argued that the core of a neurotic clinical picture is some mixture of anxiety and depressive features combined with significant personality pathology. This general neurotic picture may be more relevant clinically than dividing up the anxiety disorders into discrete entities that fail to have dramatically different treatment strategies.

The anxiety disorders underwent major changes in the development of DSM-5. Obsessive-compulsive disorder was moved out of the anxiety disorders category and instead was grouped with other disorders that share obsessions or compulsive behaviors, such as trichotillomania and body dysmorphic disorder. Similarly, posttraumatic stress disorder and acute stress disorder were relocated from the anxiety disorders to a new category of trauma- and stressor-related disorders. The core anxiety disorders are now phobic disorders, generalized anxiety disorder, panic disorder, and new additions to this category, including selective mutism and separation anxiety disorder, which were previously categorized under the disorders associated with childhood and adolescence.

Panic Disorder

Although panic attacks generally last only a matter of minutes, they produce considerable distress within the patient. In addition to experiencing alarming physiological symptoms, such as choking, dizziness, sweating, shaking, and tachycardia, patients with panic disorder often sense imminent doom. Most patients with panic disorder also have agoraphobia (i.e., a fear of being in a location or situation from which escape would be difficult or extremely embarrassing). Because panic attacks are recurrent, patients often develop a secondary form of anticipatory anxiety, worrying constantly about when and where the next attack will occur. Panic disorder patients with agoraphobia often restrict their travel to try to control the dreaded situation of having a panic attack in a place they cannot leave easily.

Panic disorder may appear psychologically contentless. The attacks may seem to come "out of the blue," without apparent environmental or intrapsychic precipitants. As a result, the psychodynamic psychiatrist's role is often—and unfortunately—deemed irrelevant in treating these patients. A significant percentage of patients with panic disorder have such attacks because of psychodynamic factors and thus may respond to psychological interventions (Milrod et al. 1997; Nemiah 1984). Psychodynamic clinicians should thoroughly investigate the circumstances of the attacks and the history of each patient with panic disorder to determine how psychological factors are relevant.

Although the evidence for neurophysiological factors in panic disorder is impressive, these observations are more persuasive regarding pathogenesis than regarding etiology. None of the neurobiological data explain what triggers the onset of a panic attack. In a pilot study involving psychodynamic interviews with nine consecutive patients with panic disorder, an objective research psychiatrist was able to identify meaningful stressors preceding the onset of the panic attacks in every case (Busch et al. 1991). These stressors tended to be connected with an alteration in the level of expectations placed on the patient. Changes in expectations related to job situations were common, as were losses associated with central figures in the patients' lives. Many of the loss events were associated with childhood experiences in which attachment to a parent or other important person had been threatened. Another common denominator among the patients investigated was the perception of parents as threatening, temperamental, critical, controlling, and demanding. More extensive analysis of the interviews demonstrated a pattern of anxiety about socializing with others during childhood, unsupportive parental relationships, and feelings of being trapped. Anger and aggression were difficult to handle for most of the patients.

Many of the observations in this exploratory study have been confirmed by empirical research. Patients with panic disorder have been found to have a higher incidence of stressful life events, particularly loss, compared with control subjects in the months preceding the onset of panic disorder (Faravelli and Pallanti 1989; Venturello et al. 2002). In another controlled study of patients with panic disorder (Roy-Byrne et al. 1986), the experimental group not only experienced significantly more stressful life events in the year preceding the onset of panic but also felt greater distress about these events in their lives than did the control subjects. In a large study of 1,018 female twin pairs (Kendler et al. 1992a), panic disorder was strongly and significantly associated with both parental separation and death. Early maternal separation in particular was linked to panic disorder. Milrod et al. (2004) noted that in some cases panic disorder may be an outcome of interpersonal loss and represent a complicated form of bereavement. In an evaluation of panic in 51 patients, 47% of the cohort experienced an onset of panic disorder within 6 weeks after a significant interpersonal loss.

One pathogenetic theory with some degree of empirical support is that panic disorder patients have a predisposing neurophysiological vulnerability that may interact with specific environmental stressors to produce the disorder. Kagan et al. (1988) identified in a number of children an inborn temperamental characteristic that they termed "behavioral inhibition to the unfamiliar." These children tend to be easily frightened by anything that is strange in their environment. As a way of coping with their fear, they rely on their parents to protect them. As they grow and mature, however, they learn

that their parents will not always be available to protect and comfort them. They may then externalize their own inadequacies by projecting them onto their parents, whom they then regard as unreliable and unpredictable. These children may become angry at their parents' inconsistent availability, but the anger creates new problems in that they worry that their angry fantasies will be destructive and drive their parents away, leaving them with the loss of a parent on whom they depend to provide safety (Busch et al. 1991; Milrod et al. 1997). A vicious circle results in which the child's anger threatens the connection with the parent and thus increases the child's fearful and hostile dependence. Separation anxiety should be thoughtfully incorporated into the formulation of patients with panic disorder because a meta-analysis of 20 studies (Kossowsky et al. 2013) indicated that children with separation anxiety disorder were more likely to develop panic disorder later on.

Understanding the pathogenesis of panic disorder from an attachment theory perspective is also helpful in a psychodynamic approach to the treatment (Shear 1996). A small preliminary study of attachment style in 18 women with anxiety disorder suggested that all had problematic attachment styles (Manassis et al. 1994). Fourteen of the 18 patients were diagnosed with panic disorder; these patients tended to have higher rates of preoccupied attachment. Patients with panic disorder often view separation and attachment as mutually exclusive. They have difficulty modulating the normal oscillation between separation and attachment because they have a heightened sensitivity to both loss of freedom and loss of safety and protection. This difficulty results in their operating within an extremely narrow range of behavior that attempts to simultaneously avoid separation that is too frightening and attachment that is too intense. This constricted comfort zone often manifests in an overcontrolling style of interaction with others typified by mentalization difficulties.

The extreme level of panic seen in these patients may reflect a signal anxiety function inadequate to activate the ego's defensive resources. Threats to attachment, in particular, appear to trigger this kind of overwhelming panic. Milrod (1998) suggested that those who develop panic disorder are prone to feelings of self-fragmentation and may need a therapist or other companion to help them feel that they have a firm sense of identity. The presence of ego defects involving self–other confusion may be related to these difficulties in using anxiety as a signal.

Another etiological factor in women patients that also relates to attachment difficulties is childhood physical and sexual abuse. In one investigation, childhood sexual abuse was found to occur at a rate of 45.1% in women with anxiety disorders, compared with a rate of 15.4% in a group of women without anxiety disorders (Stein et al. 1996). When panic disorder, in particular, was examined, 60% of the women with panic disorder had a history of childhood sexual abuse, compared with 31% of women with other anxiety

disorders. Because childhood trauma interferes with the child's attachment to the parents, sexual abuse could account for some of the difficulties that panic disorder patients have in feeling safe and secure with significant objects in their lives. Internalization of abusive representations of parents also interferes with development of trust in adult life.

DeMasi (2004) suggests that traumatic terror stored in implicit memory may be triggered by a conditioned stimulus linked to a prior danger situation. His model integrates neuroscience findings with psychodynamic understanding. In this model he draws on the work of LeDoux (1996), who noted that unconscious memories of fear established in the amygdala seem to leave indelible imprints in the brain. The amygdala is the first area of the brain to be activated when confronted with a fear signal. This activation may be entirely unconscious, and the fight/flight response may take over before the thalamus has time to relay information to the cortex so that rational thinking from the prefrontal cortex can be applied to the situation. For example, a subliminal perception of a snake may activate the amygdala, but the cortex may subsequently process the information in more detail and recognize that a harmless garter snake represents no threat whatsoever. DeMasi suggests that the overwhelming anxiety of panic disorder is stuck within the primitive amygdala/limbic system circuit and fails to be adequately processed by the forces of reason in the cortex. Hence imaginary dangers, often stemming from previous trauma, are not discriminated from real dangers.

Case reports of successful treatment of patients with panic disorder with either psychoanalysis or psychodynamic psychotherapy (Abend 1989; Milrod and Shear 1991; Milrod et al. 1997; Sifneos 1972) provide reason to believe that psychodynamic interventions have a major role to play in the treatment of panic disorder. Promising results from an open trial of panic-focused psychodynamic psychotherapy (Milrod et al. 2001) have led to a randomized controlled trial of the treatment modality that is currently under way.

In the course of psychodynamic therapy, the patient's difficulties in relationships often become centered in the transference to the therapist. Conflicts around anger, independence, and separation are especially prominent. It usually behooves the therapist to explore the patient's fears of becoming overly dependent on the therapist as the treatment progresses. Similarly, there may be undue anxiety about the loss of the therapist, either temporarily through vacations or permanently through termination of the treatment.

In many cases, fantasies of uncontrollable anger, or even murderous rage, may be central to the therapy. Parental anger may have been so intense that any eruption of anger is seen as potentially destructive. Some children may have experienced their parents as emotionally abandoning them when they expressed their anger. Examining characteristic defense mechanisms designed to avoid anger is often of considerable value. Patients with panic

disorder typically use any combination of the following defenses: reaction formation, undoing, somatization, and externalization (Busch et al. 1995). Both undoing and reaction formation can help the patient disavow negative affects such as anger. Psychotherapists may need to help patients become aware of their anxiety about expressing anger and the associated need to defend against it. In addition, the dynamic therapist must press the patient to go over the details of what precipitated a panic attack and start to connect anxieties about catastrophe with life events. In this way the patient's mentalization capacity will increase to the point at which he or she can see that something is being represented by the panic attack. In other words, the perception of a real catastrophe is only a representation rather than a reality.

Defenses of somatization and externalization often work synergistically to prevent internal reflection. In somatization, the patient's attention is focused on physiological phenomena rather than on psychological causes or meaning. In externalization, problems are attributed to external persons, who are viewed as mistreating the patient in some way. Used in combination, these defenses may create a specific form of object relationship in which others (e.g., family, friends, doctors) are enlisted as healers who are expected to fix something in the patient's body. This pattern of object relatedness frequently plays itself out in the transference as well.

Psychoanalytic psychotherapy has been shown in a randomized control trial to be efficacious for panic disorder (Milrod et al. 2007). The randomly assigned patients received either twice weekly psychodynamic psychotherapy or twice weekly sessions of applied relaxation training for 12 weeks. The therapy was based on the ideas of Milrod (1998) and Busch et al. (1995). Personal meanings of the panic symptoms were explored, and central conflicts involving separation and autonomy, anger recognition, relational issues, concern about separation, and sexuality were all addressed, including as they emerged in the transference. At the end of the 12 weeks, 73% of the patients who received the panic-focused psychodynamic psychotherapy had responded well at termination of treatment compared with 39% of those in the control group of relaxation. A manual describing this treatment was subsequently published (Busch et al. 2011).

Some patients with panic disorder benefit from a combination of medications and psychotherapy (Wiborg and Dahl 1996). Pharmacotherapy alone generally is not sufficient to cause the symptoms to remit or to improve symptomatic control over the panic attacks (Cooper 1985; Zitrin et al. 1978). Moreover, some patients present with major resistances to medication, often because they believe it stigmatizes them as being mentally ill, so psychotherapy may be necessary to help them understand and eliminate reservations about pharmacotherapy. The therapy is also useful for those with personality disorders, particularly with borderline, narcissistic, or histrionic

personality disorders. Without treatment of these conditions, the outcomes of patients with panic disorder may be adversely affected (Reich 1988).

For a comprehensive and effective treatment plan, these patients require psychotherapeutic approaches in addition to appropriate medications. In all patients with symptoms of panic disorder or agoraphobia, a careful psychodynamic evaluation will help weigh the contributions of biological and dynamic factors.

Mr. M, a 27-year-old office worker, came to an outpatient clinic with a complaint of panic attacks that occurred whenever he attempted to leave town. He was initially unable to link the panic to any psychological content, but further exploration by the evaluating psychiatrist revealed a number of contributing factors. Mr. M had just purchased a new house, and his wife was pregnant with their first child. When the psychiatrist commented on the increased responsibility associated with these events, the patient replied that he felt more like 7 than 27. He went on to say that he was not sure that he was prepared to shoulder the responsibilities of a husband and father accountable for the mortgage on a house. The psychiatrist asked Mr. M to describe in more detail the circumstances of the panic attacks. Mr. M again explained that he had them whenever he started to leave town. The psychiatrist asked about the purpose of these trips, which Mr. M explained was to go hunting with his father. The psychiatrist asked if anything unpleasant had ever happened on these trips. After a few moments' reflection, Mr. M replied that he had accidentally shot his father in two different hunting accidents, although fortunately his father had sustained only minor wounds on each occasion.

The psychiatrist then developed a tentative explanatory formulation based on his evaluation that Mr. M's panic disorder was related to psychological conflict. Recent events in his life had placed him more squarely in competition with his father as a husband, father, and breadwinner. These events activated long-standing aggressive wishes toward his father that were based on repressed and unconscious oedipal rivalry. The impulse to destroy his father had emerged in the form of accidents on two previous hunting trips. Now whenever Mr. M planned to leave town with his father to go hunting, the threatened emergence of the aggressive impulses created signal anxiety that was transformed into a full-blown panic attack because this particular patient had the underlying neural substrate necessary to transform anxiety into panic. The result was an avoidance of situations in which the destructive wishes and the imagined retaliation (castration) would be activated.

To understand the dynamic factors involved in triggering the panic, the patient began expressive-supportive psychotherapy with an expressive emphasis. As the process proceeded, Mr. M began to talk more and more about his attachment to his mother. It soon emerged that his mother had also been terrified of separations. As a child, each time Mr. M went outside, his mother would warn him about the many dangers he might encounter. Through the psychotherapy process, Mr. M eventually realized that he shared his mother's anxiety about separations. He noted that whenever his wife was away on business, he worried the entire time because he feared that she might die and

thus abandon him. The patient's oedipal anxieties were clearly compounded by more primitive anxieties about object loss, originally of his mother but now of his wife.

After approximately 2 years of psychotherapy, Mr. M was free from panic attacks and from anticipatory anxiety as well. He had received a promotion at work that he was able to handle without anxiety. His new job necessitated driving out of town almost every workday, and he was able to do so without experiencing any panic.

Several years later, Mr. M returned for further treatment when two life events reactivated the underlying neural structure that mediated his panic attacks. A private business he had started had become enormously successful, resulting in a much more affluent lifestyle. Moreover, his father had been diagnosed as having incurable cancer. This time a combination of medication (alprazolam) and psychotherapy was required to reduce Mr. M's panic attacks to manageable proportions.

Phobias

Phobias included in the DSM-5 classification of anxiety disorders include specific phobias, social anxiety disorder or social phobia, and agoraphobia. The psychodynamic understanding of phobias illustrates the neurotic mechanism of symptom formation described at the beginning of this chapter. When forbidden sexual or aggressive thoughts that might lead to retaliatory punishment threaten to emerge from the unconscious, signal anxiety is activated, which leads to the deployment of three defense mechanisms: displacement, projection, and avoidance (Nemiah 1981). These defenses eliminate the anxiety by once again repressing the forbidden wish, but the anxiety is controlled at the cost of creating a phobic neurosis. A clinical example illustrates the phobic symptom formation more elaborately.

Mr. N was a 25-year-old junior executive who had just completed a master's degree program in business administration and taken his first position with a corporation. He had developed a social phobia that involved an intense fear of meeting new people at work or in social situations. He also developed intense anxiety whenever he had to speak in front of a group of people at work. When forced to confront the feared situations, he would become short of breath and stumble over his words to such an extent that he could not complete sentences.

Brief dynamic therapy was recommended for Mr. N because of his notable ego strengths, the focal nature of his symptom, his good overall functioning, his high level of motivation, and his considerable psychological mindedness. In the third session, Mr. N clarified for the therapist that the worst part of meeting new people was having to introduce himself. The following exchange took place:

THERAPIST: What's difficult about saying your name?
MR. N: I have no idea.
THERAPIST: If you reflect about your name for a minute, what comes to mind?
MR. N (*after a pause*): Well, it's also my father.
THERAPIST: How does that make you feel?
MR. N: A bit uncomfortable, I guess.
THERAPIST: Why is that?
MR. N: Well, I haven't had a great relationship with him. Ever since he left my mom when I was 4 years old, I've seen very little of him.
THERAPIST: So you had to live alone with your mother after he left?
MR. N: That's right. My mom never remarried, so I had to be the man of the house from an early age, and I didn't feel ready to take on so much responsibility. I've always resented that. When I was a kid, everybody always said that I acted like such an adult. That used to bother me because I felt like I was just pretending to be an adult when I was really a child inside. I felt like I was fooling everybody, and if they found out, they would be mad at me.
THERAPIST: I wonder if that's how you feel now when you introduce yourself.
MR. N: I think that's exactly how I feel. To say my name is to say I'm trying to be my father.

The therapist's interpretation helped Mr. N realize that his anxiety was related to guilt and shame about prematurely filling his father's shoes. He imagined that others would see through this charade, or deceit, and disapprove of him. After 10 sessions of brief dynamic therapy, the patient overcame his social phobia and was able to function well at work and in social settings.

At the height of Mr. N's oedipal phase of development, his father left him alone with his mother. In that original anxiety-generating situation, he had feared castration or retaliatory punishment (from his father) for taking his father's place with his mother. As an adult, Mr. N dealt with anxiety by displacing the original feared situation onto an insignificant and seemingly trivial derivative of that situation, namely, saying his name during introductions. Symbolically, this simple social grace had taken on the meaning of replacing his father. The patient's second defensive maneuver was to project the feared situation outward onto the environment so that the threatened punishment or disapproval came from external rather than internal sources (i.e., the superego). The patient's third and final defense mechanism was avoidance. By avoiding all situations in which he had to introduce himself or speak in front of others, Mr. N could maintain control over his anxiety at the cost of restricting his social life and jeopardizing his performance at work.

Mr. N's anxiety about speaking in front of others is widely shared. In one metropolitan survey (Pollard and Henderson 1988), one-fifth of the individuals contacted in the city of St. Louis had a social phobia about public speaking or performing. When the investigators modified that figure by including the "significant distress" criteria of DSM-III (American Psychiatric Association 1980), the prevalence rate fell to 2%. Exact figures on social phobia are difficult to ascertain, however, because the diagnosis is often applied to general interpersonal patterns of shyness and avoidance of the opposite sex because of fear of rejection. The continuum ranges from social phobia at one end to a generalized characterological style of relating, known as avoidant personality disorder (see Chapter 19), at the other. Despite the high prevalence of social anxiety disorder in the general population, more than 80% of individuals in a national epidemiological survey had received no treatment for the condition (Grant et al. 2005).

Phobias fit nicely into a model of genetic-constitutional diathesis in interaction with environmental stressors. Kendler et al. (1992b) studied 2,163 female twins and concluded that the best model for the disorder is an inherited phobia proneness that requires environmental etiological factors specific to the individual to produce a full-blown phobic syndrome. In their study population, one of the clear environmental stressors associated with an increased risk for phobia was parental death before age 17 years (Kendler et al. 1992a). Specific parenting style has also been linked in the development of social phobia in youth. Lieb et al. (2000) followed up a cohort of 1,047 adolescents and identified a perceived parenting style of overprotection and rejection, along with parental psychopathology (particularly depression and social phobia), as instrumental in the development of social phobia in this cohort. A prospective follow-up study of 238 children from birth to grade 9 found that exposure to maternal stress during infancy and in the preschool period may also be a major factor contributing to the development of social anxiety disorder (Essex et al. 2010).

Data from positron emission tomography studies suggest that patients with social phobia, like patients with panic disorder, may have a strong component of subcortical activity underlying their fear. Tillfors et al. (2001) compared regional cerebral blood flow (rCBF) in subjects with social phobia with rCBF in a group who were speaking in front of an audience but did not suffer from social phobia. Patients with social phobia showed an rCBF profile associated with increased subcortical activity in the amygdaloid complex, whereas the nonphobic subjects showed a pattern of relatively increased cortical perfusion.

The work of Kagan et al. (1988) on behavioral inhibition appears to be applicable to social phobia in much the same way that it is relevant to panic disorder. Although Kagan and colleagues found that infants with this temperament are born with a lower threshold for limbic-hypothalamic arousal

in response to unexpected changes in the environment, they also concluded that some form of chronic environmental stress must act on the original temperamental disposition to result in shy, timid, and quiet behavior at 2 years of age. They postulated that stressors such as humiliation and criticism from an older sibling, parental arguments, and death of or separation from a parent were probably among the chief contributory environmental factors.

Rosenbaum et al. (1992) extended the work of Kagan et al. (1988) by evaluating parents of behaviorally inhibited children from a nonclinical cohort studied by Kagan. Parents of these children were at greater risk for anxiety disorders, mainly social phobia. Parents of the children with behavioral inhibition and anxiety had significantly higher rates of two or more anxiety disorders as compared with two different sets of parents in control groups. One possible interpretation of their findings is that those children with behavioral inhibition who go on to develop manifest anxiety disorders are exposed to parents with greater anxiety who may convey to the children that the world is a dangerous place. Moreover, high expressed emotion, and maternal criticism in particular, appear to mediate the relationship between maternal anxiety disorder and child behavioral inhibition, leading to a risk for psychopathology (Hirshfeld et al. 1997).

Social phobia is a condition with a high rate of comorbidity. In a study of 13,000 adults (Schneier et al. 1992), lifetime major comorbid disorders were present in 69% of subjects with social phobia. These investigators made the point that in the absence of comorbidity, social phobia is rarely treated by mental health professionals. One can postulate that the genetic-constitutional diathesis described by Kagan et al. (1988), Rosenbaum et al. (1992), and others may predispose to a number of anxiety disorders.

Clinical work with socially phobic patients reveals that certain characteristic internal object relationships are present. Specifically, these patients have internalized representations of parents, caretakers, or siblings who shame, criticize, ridicule, humiliate, abandon, and embarrass (Gabbard 1992). These introjects are established early in life and then repeatedly projected onto persons in the environment, who are then avoided. Although these patients may have a genetic predisposition to experience others as hurtful, positive experiences can mitigate those effects to some extent. It is as though a genetically programmed template were present at birth. To the extent that caretakers behave like the programmed template, the individual will become increasingly fearful of others and develop social phobia. To the extent that caretakers are sensitive to the child's fearfulness and compensate, the introjects will be more benign, less threatening, and less likely to produce the adult syndrome of social phobia.

Although many patients with social phobia respond well to selective serotonin reuptake inhibitors (SSRIs) and/or cognitive-behavioral therapy,

dynamic therapy can be useful as well. Some patients have particularly treatment-resistant illness because they fear any situation in which they might be judged or criticized. Because the therapeutic setting is viewed as just such a situation, a transference fear of being humiliated or judged may lead patients to miss appointments frequently or to stop coming to treatment altogether. In fact, because of the disorder's high rates of comorbidity, social phobia may only be discovered when a patient seeks treatment for another reason. Embarrassment and shame are central affective states, and the therapist who tunes in to these affects may have a better chance of forming a therapeutic alliance in the initial visits with the patient. Exploring their fantasies of how the therapist and others might react to them will also help these patients begin to appreciate that their perceptions of how others feel about them may be different from how others actually feel about them. Treatment resistance should be dealt with aggressively, because without treatment, these patients often avoid school or work and many end up on welfare or disability (Schneier et al. 1992).

Psychodynamic therapy for social anxiety disorder was tested in a multicenter randomized control trial with cognitive-behavioral therapy (CBT) as a control (Leichsenring et al. 2013). The type of dynamic therapy used was based on Luborsky's (1984) model of psychodynamic therapy specifically adapted to treat social anxiety disorder. Both CBT and psychodynamic therapy were efficacious in the treatment of social anxiety disorder, but there were significant differences in favor of CBT. One feature of this study that reflects common practice in clinical settings is that even psychodynamic therapists encouraged patients to face the feared situation that haunted them, whether it was a job interview or attendance at a class. The therapist did not, however, accompany the patient to any of the feared situations.

Most of the focus in this chapter regarding phobias has been on social anxiety disorder. Specific phobias generally respond well to in vivo exposure and do not require psychodynamic treatment. However, the interpersonal ramifications of agoraphobias often benefit from a dynamic approach. By virtue of being housebound, severely agoraphobic individuals often require caretaking from another significant person, such as a spouse or parent. It is common, for example, for an agoraphobic woman and her husband to have accommodated to her condition over a period of many years. The husband may actually feel more secure knowing that his wife is always in the house. If the agoraphobia is treated, the couple's equilibrium may destabilize. The husband may become more anxious because of a fear that his wife will begin to seek out other men now that she is leaving the house. Adequate assessment and treatment of phobias must include a careful assessment of how the phobia fits into the patient's network of relationships. A psychodynamic understanding of the interpersonal context of a phobia may thus be crucial to

dealing with resistances to conventional treatments such as behavioral desensitization and medication.

Generalized Anxiety Disorder

The DSM-5 criteria for generalized anxiety disorder (GAD) have sought to clarify the boundary between this disorder and normal worry. The anxiety must be excessive, difficult to control, and frequent enough that it occurs more days than not for at least a 6-month period. It must also cause clinically significant distress or impair occupational, social, or other important areas of functioning. The diagnosis requires that the focus of the anxiety not be confined to features of other disorders, such as worry about having a panic attack, concern about contamination, fear of being embarrassed in public, and so forth.The anxiety and worry must be associated with three or more of the following six symptoms, with the idea that at least some symptoms have been present for more days than not during the past 6 months: 1) restlessness or feeling keyed up or on edge, 2) being easily fatigued, 3) difficulty concentrating or mind going blank, 4) irritability, 5) muscle tension, or 6) sleep disturbance (difficulty falling or staying asleep or restless, unsatisfying sleep).

GAD continues to be controversial. Of all the anxiety disorders, it is associated with the highest rate of comorbidity. In a multicenter study (Goisman et al. 1995), almost 90% of patients with GAD had a lifetime history of at least one other anxiety disorder. At any rate, clinicians commonly encounter patients who are chronic worriers, and because many of these patients have difficulty working as a result of their pervasive anxiety, treatment may be extremely important for them.

Psychodynamic psychotherapy may be ideally suited for generalized anxiety disorder as a way of deconstructing the factors that are producing the anxiety, both conscious and unconscious. Leichsenring et al. (2009) conducted a study comparing short-term psychodynamic psychotherapy and CBT in the treatment of generalized anxiety disorder. The patients were randomly assigned to either treatment, and the treatment was carried out according to treatment manuals in up to 30 weekly sessions. Both CBT and short-term psychodynamic psychotherapy resulted in large, significant, and stable improvements with regard to symptoms of anxiety. No significant differences in outcome were found between the treatments in regard to the primary outcome measure.

All clinicians are faced with matching the best treatment to the characteristics of the patient. Large-scale group designs tell the clinician little about determining which individual is likely to benefit from which treatment (Barlow and Beck 1984). Worry and anxiety appear in response to numerous sit-

uations over the course of the life cycle. Developmental phases of life are often instrumental in producing the worry. Clinicians may be tempted to simply prescribe medication rather than listening to the patient's story. However, more far reaching results may be achieved by taking the time to consider how this particular patient has come to this particular symptom at this particular phase in life. The following clinical vignette is illustrative.

Ms. O was a 23-year-old graduate student who came for consultation because of periodic episodes of intense anxiety. About three times a month she would begin worrying about death while lying in bed. Typically, she would start ruminating in the following manner: "I am 23 now; in only 7 years, I'll be 30. Then I'll be 40, and my kids will be grown. Then I'll be a grandparent and retire, and then I'll die." These thoughts led to concerns that her parents, both of whom were alive and well, would soon die. As these thoughts escalated, the anxiety she experienced increased to the point at which her heart was racing and she could not fall asleep.

After a diagnostic evaluation, several possible interventions were discussed with her: prescription of antianxiety medication, psychotherapeutic exploration of the causes of anxiety, or a combination of the two. She replied pointedly that she had no interest in medication. "How can a pill make my fear of death go away?" she inquired. She made it clear that she wanted to understand the origins of her anxiety so she could master her fears.

She embarked on a course of psychotherapy that led to increasing ideational mastery over the disturbing affect. Her therapist empathized with Ms. O regarding the frightening nature of death but also noted that concerns about living often contributed to fears about death. He asked her what was going on in her life that might contribute to her anxiety. She immediately replied that it had nothing to do with her husband's being stationed overseas. Her eyes started to tear up, and her therapist handed her a box of tissues.

Ms. O ignored the box of tissues and continued talking about how young people were dying of AIDS and cancer. Her therapist asked her why she had not taken a tissue when it was offered to her. She said she thought it would have been a sign of weakness. Her therapist inquired if it had always been difficult for her to acknowledge that she needed the help of other people. She responded that all her life everyone had told her their problems, and she could never acknowledge that she had problems and needed help from others. Her therapist suggested to her that she might need to present a pseudoindependent facade as a way of denying her neediness. She readily acknowledged that she dreaded the feeling of weakness associated with being vulnerable and needy. Her therapist pointed out to her that death was the ultimate situation of vulnerability and neediness. She then responded that the worst thing about death, in her mind, would be having to go through it alone.

As Ms. O continued to explore sources of her anxiety, she revealed a history of having significant difficulties with the expression of anger. She feared that her anger would come out in an explosion that would drive others away from her. Her nighttime anxiety often arose after seeing violent movies. She said it bothered her a great deal that others expressed their anger in such a violent, forthright manner while she worked so diligently to control hers.

Further psychotherapeutic exploration led to the uncovering of a good deal of anger at her father that she had been unable to express. Her unconscious concern was that her anger would be so explosive that it would destroy him.

After 2 months of psychotherapy, the episodes of intense anxiety disappeared. Ms. O still worried about death to some extent, but she had developed greater mastery over the fear as she understood the underlying concerns about the impact of her anger and her fears of being abandoned and alone. In other words, a broadened ideational mastery of the affect enabled her to control her symptoms.

The case of Ms. O illustrates the time-honored principle that in clinical psychiatry we must adapt the treatment to the patient. Contrary to the point of view of some third-party payers, the most appropriate treatment for a patient is not necessarily the most cost-effective. Although some clinicians would argue that an antianxiety agent might have more quickly and more cheaply eliminated the patient's symptom, Ms. O was asking for something other than symptom relief. As Barber and Luborsky (1991) argue, specific anxiety disorder diagnoses require different treatments in different circumstances with different patients. Psychodynamic psychotherapy may be the treatment of choice for the patient who is psychologically minded, motivated to understand the matrix from which the symptom arises, and willing to invest the time, money, and effort in a therapy process. Ms. O did not ask for medication and would probably not have taken it if it had been prescribed.

Medication may at times be a crucial short-term adjunct to psychotherapeutic interventions for GAD. However, it must not be oversold to patients as a definitive treatment for anxiety. Patients need to learn to tolerate anxiety as a meaningful signal in the course of psychotherapy. Those with reasonably good ego strength come to view anxiety as a window into the unconscious.

The treatment of anxiety must begin with a thoughtful and thorough psychodynamic evaluation, with anxiety conceptualized as a multidetermined "tip of the iceberg." The clinician must diagnose the nature of the patient's underlying fear (see Table 9–1). In addition, the role of anxiety in the patient's personality organization must be assessed. What is the ego's capacity to tolerate anxiety and to endure an exploration of the anxiety's origins? Do particular constellations of internal object relations seem to evoke anxiety? Is the anxiety connected with concerns about dissolution of the self? Prescribing the appropriate psychodynamic intervention depends partly on the patient's clinical situation and interests. Some patients may respond quickly and well to brief educational and clarifying comments and then require no further treatment. Others who have highly focal symptoms and certain notable ego strengths may have their anxiety ameliorated with brief dynamic therapy. Neurotic patients with fewer focal complaints and a more thoroughgoing interest in fundamental personality change may require psy-

choanalysis. Finally, patients with serious character pathology who complain of anxiety will need long-term expressive-supportive psychotherapy before they are likely to experience symptom relief.

When psychodynamic therapy is undertaken with GAD patients, the therapist needs to be tolerant of the patient's focus on somatic symptoms and other worries that sound rather superficial. A working hypothesis regarding the defensive function is that focusing on these worries distracts the patient from more disturbing underlying concerns. This characteristic defensive pattern of avoidance may be linked to insecure conflicted attachment in childhood as well as to early traumas (Crits-Christoph et al. 1995). After listening empathically to the patient's presenting concerns, the therapist can begin to inquire about family relationships, interpersonal difficulties, and the patient's work situation. The therapist then can make linkages among the various situations of worry so that patterns of core conflicts in relationships begin to emerge. As in all dynamic therapy, some of the most persuasive evidence of these patterns may emerge in the transference relationship. As the sources of anxiety become linked to recurrent conflicts, the patient comes to realize that the anxiety can be mastered through an understanding of the unconscious expectations of failure in relationships and at work. A positive outcome may also be a capacity to use anxiety as a signal of a recurrent conflict that leads to introspection and further understanding.

References

Abend SM: Psychoanalytic psychotherapy, in Handbook of Phobia Therapy: Rapid Symptom Relief in Anxiety Disorders. Edited by Lindemann C. Northvale, NJ, Jason Aronson, 1989, pp 395–403

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Appelbaum SA: The Anatomy of Change: A Menninger Report on Testing the Effects of Psychotherapy. New York, Plenum, 1977

Barber JP, Luborsky L: A psychodynamic view of simple phobia and prescriptive matching: a commentary. Psychotherapy 28:469–472, 1991

Barlow DH, Beck JG: The psychosocial treatment of anxiety disorders: current status, future directions, in Psychotherapy Research: Where Are We and Where Should We Go? Edited by Williams JBW, Spitzer RL. New York, Guilford, 1984, pp 29–69

Busch FN, Cooper AM, Klerman GL, et al: Neurophysiological, cognitive-behavioral, and psychoanalytic approaches to panic disorder: toward an integration. Psychoanalytic Inquiry 11:316–332, 1991

Busch FN, Shear MK, Cooper AM, et al: An empirical study of defense mechanisms in panic disorder. J Nerv Ment Dis 183:299–303, 1995

Busch FN, Milrod BL, Singer MB, et al: Manual of Panic-Focused Psychodynamic Psychotherapy. Hoboken, NJ, Taylor and Francis, 2011

Cooper AM: Will neurobiology influence psychoanalysis? Am J Psychiatry 142:1395–1402, 1985

Crits-Christoph P, Crits-Christoph K, Wolf-Palacio D, et al: Brief supportive-expressive psychodynamic therapy for general anxiety disorder, in Dynamic Therapies for Psychiatric Disorders (Axis I). Edited by Barber JP, Crits-Christoph P. New York, Basic Books, 1995, pp 43–83

De Masi F: The psychodynamic of panic attacks: a useful integration of psychoanalysis and neuroscience. Int J Psychoanal 85:311–336, 2004

Essex MJ, Klein MH, Slattery MJ, et al: Early risk factors and developmental pathways to chronic high ambition and social anxiety disorder in adolescents. Am J Psychiatry 167:40–46, 2010

Faravelli C, Pallanti S: Recent life events and panic disorder. Am J Psychiatry 146:622–626, 1989

Freud S: Inhibitions, symptoms and anxiety (1926), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 20. Translated and edited by Strachey J. London, Hogarth Press, 1959, pp 75–175

Freud S: On the grounds for detaching a particular syndrome from neurasthenia under the description "anxiety neurosis" (1895), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 3. Translated and edited by Strachey J. London, Hogarth Press, 1962, pp 85–117

Gabbard GO: Psychodynamics of panic disorder and social phobia. Bull Menninger Clin 56(suppl A):A3–A13, 1992

Gabbard GO, Nemiah JC: Multiple determinants of anxiety in a patient with borderline personality disorder. Bull Menninger Clin 49:161–172, 1985

Goisman RM, Goldenberg I, Vasile RG, et al: Comorbidity of anxiety disorders in a multicenter anxiety study. Compr Psychiatry 36:303–311, 1995

Grant BF, Hasin DS, Blanco C, et al: The epidemiology of social anxiety disorder in the United States: results from a national epidemiologic survey on alcohol related conditions. J Clin Psychiatry 66:1351–1361, 2005

Hariri AR, Mattay VS, Tessitore A, et al: Serotonin transporter genetic variation and the response of the human amygdala. Science 297:400–403, 2002

Hettema JM, Prescott CA, Myers JM, et al: The structure of genetic and environmental risk factors for anxiety disorders in men and women. Arch Gen Psychiatry 62:182–189, 2005

Hirshfeld DR, Biederman J, Brody L, et al: Expressed emotion toward children with behavioral inhibition: associations with maternal anxiety disorder. J Am Acad Child Adolesc Psychiatry 36:910–917, 1997

Kagan J, Reznick JS, Snidman N: Biological bases of childhood shyness. Science 240: 167–171, 1988

Kendler KS, Neale MC, Kessler RC, et al: Childhood parental loss and adult psychopathology in women: a twin study perspective. Arch Gen Psychiatry 49:109–116, 1992a

Kendler KS, Neale MC, Kessler RC, et al: The genetic epidemiology of phobias in women: the interrelationship of agoraphobia, social phobia, situational phobia, and simple phobia. Arch Gen Psychiatry 49:273–281, 1992b

Kendler KS, Gardner CO, Annas P, et al: A longitudinal peer twin study of fears from middle childhood to early adulthood: evidence for a developmentally dynamic genome. Arch Gen Psychiatry 65:421–429, 2008

Kossowsky J, Pfaltz MC, Schneider S: The separation anxiety hypothesis of panic disorder revisited: a meta-analysis. Am J Psychiatry 170:768–781, 2013

Leichsenring F, Salzer S, Jaeger U, et al: Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. Am J Psychiatry 166:875–881, 2009

Leichsenring F, Salzer S, Beutel ME, et al: Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: a multicenter randomized controlled trial. Am J Psychiatry 170:759–767, 2013

LeDoux J: The Emotional Brain: The Mysterious Underpinnings of Emotional Life. London, Weidenfeld & Nicolson, 1996

Lesch KP, Bengel D, Heils A, et al: Association of anxiety-related traits with a polymorphism in the serotonin transporter gene regulatory region. Science 274:1527–1531, 1996

Lieb R, Wittchen HU, Hofler M, et al: Parental psychopathology, parenting styles, and the risk of social phobia in offspring: a prospective-longitudinal community study. Arch Gen Psychiatry 57:859–866, 2000

Luborsky L: Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment. New York, Basic Books, 1984

Manassis K, Bradley S, Goldberg S, et al: Attachment in mothers with anxiety disorders and their children. J Am Acad Child Adolesc Psychiatry 33:1106–1113, 1994

Milrod B: Unconscious pregnancy fantasies as an underlying dynamism in panic disorder. J Am Psychoanal Assoc 46:673–690, 1998

Milrod B, Shear MK: Psychodynamic treatment of panic: three case histories. Hosp Community Psychiatry 42:311–312, 1991

Milrod BL, Busch FN, Cooper AM, et al: Manual of Panic-Focused Psychodynamic Psychotherapy. Washington, DC, American Psychiatric Press, 1997

Milrod B, Busch F, Leon AC, et al: A pilot open trial of brief psychodynamic psychotherapy for panic disorder. Journal of Psychotherapy Research 10:239–245, 2001

Milrod B, Leon AC, Shear MK: Can interpersonal loss precipitate panic disorder? (letter). Am J Psychiatry 161:758–759, 2004

Milrod B, Leon AC, Busch F, et al: A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. Am J Psychiatry 164:265–272, 2007

Nemiah JC: A psychoanalytic view of phobias. Am J Psychoanal 41:115–120, 1981

Nemiah JC: The psychodynamic view of anxiety, in Diagnosis and Treatment of Anxiety Disorders. Edited by Pasnau RO. Washington, DC, American Psychiatric Press, 1984, pp 115–137

Pollard CA, Henderson JG: Four types of social phobia in a community sample. J Nerv Ment Dis 176:440–445, 1988

Reich JH: DSM-III personality disorders and the outcome of treated panic disorder. Am J Psychiatry 145:1149–1152, 1988

Rosenbaum JF, Biederman J, Bolduc EA, et al: Comorbidity of parental anxiety disorders as risk for childhood-onset anxiety in inhibited children. Am J Psychiatry 149:475–481, 1992

Roy-Byrne PP, Geraci M, Uhde TW: Life events of the onset of panic disorder. Am J Psychiatry 143:1424–1427, 1986

Sareen J, Cox BJ, Afifi TO, et al: Anxiety disorders and risk for suicidal ideation and suicide attempts: a population-based longitudinal study of adults. Arch Gen Psychiatry: 62:1249–1257, 2005

Schneier FR, Johnson J, Hornig CD, et al: Social phobia: comorbidity and morbidity in an epidemiological sample. Arch Gen Psychiatry 49:282–288, 1992

Shear MK: Factors in the etiology and pathogenesis of panic disorder: revisiting the attachment-separation paradigm. Am J Psychiatry 153(suppl):125–136, 1996

Siegal RS, Rosen IC: Character style and anxiety tolerance: a study of intrapsychic change, in Research in Psychotherapy, Vol 2. Edited by Strupp H, Luborsky L. Baltimore, MD, French-Bray Printing Co, 1962, pp 206–217

Sifneos PE: Short-Term Psychotherapy and Emotional Crisis. Cambridge, MA, Harvard University Press, 1972

Stein MB, Walker JR, Anderson G, et al: Childhood physical and sexual abuse in patients with anxiety disorders and in a community sample. Am J Psychiatry 153: 275–277, 1996

Tillfors M, Furmark T, Marteinsdottir I, et al: Cerebral blood flow in subjects with social phobia during stressful speaking tasks: a PET study. Am J Psychiatry 158: 1220–1226, 2001

Tyrer P, Seivewright H, Johnson T: The core elements of neurosis: mixed anxiety-depression (cothymia) and personality disorder. J Pers Disord 17:129–138, 2003

Venturello S, Barzega G, Maina G et al: Premorbid conditions and precipitating events in early onset panic disorder. Compr Psychiatry 43:28–36, 2002

Wiborg IM, Dahl AA: Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? Arch Gen Psychiatry 53:689–694, 1996

Wong PS: Anxiety, signal anxiety, and unconscious anticipation: neuroscientific evidence for an unconscious signal function in humans. J Am Psychoanal Assoc 47: 817–841, 1999

Zitrin CM, Klein DF, Woerner MG: Behavior therapy, supportive psychotherapy, imipramine, and phobias. Arch Gen Psychiatry 35:307–316, 1978

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CHAPTER 10

TRAUMA- AND STRESSOR-RELATED DISORDERS AND DISSOCIATIVE DISORDERS

In recent years, psychiatric interest in dissociation has grown in conjunction with the interest in posttraumatic stress disorder (PTSD) and responses to trauma in general. Psychoanalytic thinking traditionally focused on unconscious needs, wishes, and drives in concert with the defenses against them. Intrapsychic fantasy played a greater role than external trauma. Dissociative disorders and PTSD have leveled the playing field so that contemporary psychodynamic clinicians now give equal weight to the pathogenetic influences of real events. The growing body of research on reactions to trauma has led to new categorizations in the DSM-5 system (American Psychiatric Association 2013). Although PTSD was formerly included among the anxiety disorders, the revision in DSM-5 groups acute stress disorder, PTSD, adjustment disorder, and reactive attachment disorder into a new category designated as *trauma- and stressor-related disorders*. A greater understanding of PTSD and acute stress disorder has broadened the array of responses to adverse events such that there is no longer a requirement that a subjective specific response to the adverse event must be one of fear or helplessness or horror. Large numbers of people numb themselves during an adverse event that is experienced directly or indirectly and begin to have symptoms after a period of time. PTSD now includes four distinct symptom clusters: reexperiencing, avoidance, persistent negative alterations in mood, and cognition and arousal. Finally, the new dissociative subtype has been added to PTSD that

requires all of the DSM-5 PTSD symptoms plus depersonalization and/or derealization.

Changes have also occurred in the conceptualization of the dissociative disorders in DSM-5. Dissociative fugue has been included as a specifier of dissociative amnesia, so it is no longer listed as a separate diagnosis. The definition of dissociative identity disorder has been altered to emphasize the intrusive nature of the dissociative symptoms as disruptions in consciousness, including an experience of possession as an alteration of identity, and an awareness that amnesia for everyday events, not merely traumatic events, is typical. Finally, derealization is no longer separate from depersonalization disorder.

In this chapter, I include both trauma- and stressor-related disorders and dissociative disorders because of their similar origins in traumatic experience.

Trauma- and Stressor-Related Disorders

Research suggests that trauma is virtually a universal experience, with 89.6% of Americans having been exposed to a traumatic event in their lifetime (Breslau 2009). PTSD itself afflicts approximately 6.8% of Americans (Kessler et al. 2005). Almost 40% of individuals who receive the diagnosis of PTSD continue to have significant symptoms a decade after onset (Kessler et al. 1995), and many have significant work impairment (Davidson 2001). As noted in Chapter 1, there is some thought that genetic vulnerability interacts with adult traumatic events and childhood adversity to increase the risk of PTSD. A study of acute and posttraumatic stress symptoms subsequent to a university campus shooting (Mercer et al. 2012) suggested that the 5-*HTTLPR* multimarker genotype may serve as a useful predictor of risk for PTSD-related symptoms in the weeks and months following trauma. It is also clear from numerous studies that child abuse itself provides significant risk liability for the development of adult PTSD. Child abuse increases the vulnerability by altering the hypothalamic-pituitary-adrenal axis functioning and by altering the nature of the attachment profile of the young child. In addition, child abuse appears to interact with genetic factors. In a study involving highly traumatized inner city individuals (Binder et al. 2008), four single nucleotide polymorphisms of the FKBP5 gene interacted with the severity of child abuse to predict adult PTSD symptoms. The investigators could not find significant genetic interactions with trauma that did not involve child abuse as a predictor of adult PTSD symptoms. One of the implications of the study is that specific variations in a stress-related gene can be influenced by trauma at a young age, specifically forms of childhood abuse.

Certain types of children seem to be more vulnerable to ultimately developing PTSD symptoms. Prospective studies of children exposed to trauma show that traumatic events are fairly common and do not often result in a full-blown picture of PTSD. However, children who have preexisting anxiety and/or depression appear to be a greater risk for the development of PTSD following trauma exposure (Copeland et al. 2007; Storr et al. 2007).

Whereas the severity of posttraumatic symptoms was once thought to be directly proportional to the severity of the stressor, empirical studies suggest otherwise. The incidence of PTSD is actually rather low among people who are healthy before experiencing the trauma (Schnyder et al. 2001). Events that seem to be relatively low in severity may trigger PTSD in certain individuals because of the subjective meaning assigned to the event. Old traumas may be reawakened by present-day circumstances. One investigation of 51 burn patients (Perry et al. 1992) showed that PTSD was predicted by smaller burns, by less perceived emotional support, and by greater emotional distress. More severe or extensive injury did not predict posttraumatic symptoms. The findings of this study are in keeping with the growing consensus that PTSD is perhaps dependent more on subjective issues, such as individual meanings and the interaction of genetic and environmental factors in one's history, than on the severity of the stressor.

Psychotherapy is generally the treatment of choice for PTSD, and a number of psychological treatments may be useful, including cognitive-behavioral, interpersonal, dynamic, and eclectic approaches (Youngner et al. 2014). Reviews of the literature suggest that PTSD is most effectively treated with trauma-focused therapy, with meta-analyses demonstrating strong responses to cognitive-behavioral therapy (CBT; Bradley et al. 2005). CBT techniques generally focus on having the patient confront rather than avoid his or her traumatic memories while also confronting distorted cognitions surrounding the trauma that allow PTSD symptoms to persist. Psychodynamic therapy may be useful with some PTSD patients but lacks strong evidence from clinical trials (Forbes et al. 2010).

Psychodynamic approaches that emphasize the careful building of a therapeutic alliance may be useful in many cases. As noted earlier, a dissociative subtype of PTSD has been added to DSM-5. Lanius et al. (2010) identified neurobiological features of dissociative PTSD that differentiate it from the more traditional subtype involving hyperarousal symptoms. The nondissociative subtype of PTSD, characterized by reexperiencing and hyperarousal, is regarded as a form of emotion dysregulation that involves emotional undermodulation. This type is mediated by failure of the prefrontal inhibition of the limbic regions. By contrast, the dissociative subtype of PTSD involves emotional *overmodulation* mediated by midline prefrontal inhibition of the same limbic regions. Exposure treatments must be used with

great caution in patients who have significant emotional overmodulation. These symptoms may prevent emotional engagement with trauma-related information, thus reducing treatment effectiveness (Lanius et al. 2010). In a study of borderline personality disorder (Kleindienst et al. 2011), levels of dissociation served as an important negative predictor of response to behavioral and exposure treatments. Hence, dissociative symptoms must be carefully assessed before proceeding to an exposure-based treatment for PTSD patients. These patients require a phase-based intervention that includes identifying and modifying attachment schemas and developing mood regulation skills.

Brom et al. (1989) compared patients receiving dynamic therapy, hypnotherapy, and systemic desensitization. All three treatment groups with PTSD showed more improvement in symptoms than a control group. Dynamic therapy achieved greater reduction in avoidant symptoms but had less impact on intrusive symptoms. The desensitization and hypnotherapy group showed the reverse pattern. Behavioral techniques have proven to be effective, but the relaxation necessary for behavioral modalities may be difficult for PTSD patients to achieve because of their impaired self-soothing abilities.

Lindy et al. (1983) used a manualized brief dynamic therapy consisting of 6–12 sessions. In a well-controlled study of this treatment with survivors of fires, these investigators demonstrated significant improvement in the 30 patients who participated, 19 of whom met DSM- (American Psychiatric Association 1980) criteria for PTSD alone or with comorbid depression.

Regardless of the type of treatment used, individual psychotherapy must be highly personalized for patients with PTSD. Dropout rates as high as 50% and nonresponse are fairly common in the literature on PTSD treatment (Schottenbauer et al. 2008). A significant subgroup of patients will be overwhelmed by the reconstruction of the trauma and will react with clinical deterioration. The integration of split-off traumatic experiences must be titrated in keeping with the particular patient's capacity for such integration. The therapist must be willing to contain projected aspects of the traumatized self until the patient is able to reintegrate them. Clinicians must be vigilant to the risk of suicide, especially with combat veterans. Hendin and Haas (1991) found that combat-related guilt was the most significant predictor of the wish to kill oneself in veterans. Many of these patients felt that they deserved to be punished because they had been transformed into murderers.

Because of these considerations, the dynamic psychotherapy of patients with PTSD must strike a balance between an observing, detached posture that allows the patient to withhold distressing information and a stance of gentle encouragement that helps the patient reconstruct a complete picture of the trauma. Integrating the memory of the trauma with the patient's continuous sense of self may be an unrealistic goal because the patient must not

be forced to proceed at a pace that becomes overwhelming and disorganizing. The building of a solid therapeutic alliance in which patients feel safe is critical for the therapy to succeed. Education about common reactions to trauma may facilitate such an alliance. An empathic validation of the patient's right to feel the way that he or she does may also further the alliance.

Regardless of the type of therapy one is conducting, an emphasis on building and repairing the therapeutic alliance is essential in the treatment of PTSD. Ruptures in the therapeutic alliance are common in prolonged exposure, and repair of those ruptures must be a high priority for the therapist. In a study of 116 PTSD patients undergoing 10 weeks of prolonged exposure therapy (McLaughlin et al. 2013), ruptures in the alliance occurred at a frequency of 46%. Moreover, unrepaired ruptures predicted worse treatment outcome.

Lindy (1996) identified four kinds of transferences that are common with PTSD patients: 1) the transfer of figures involved in the traumatic event onto the therapist, 2) the transference of specific disavowed memories of the traumatic event onto the treatment situation, 3) the transfer onto the therapist of intrapsychic functions in the patient that had been distorted as a result of the trauma (with the hope that healthier function will be restored), and 4) the transfer onto the therapist of an omnipotent and wide role in which the therapist can help the patient sort out what happened and restore a sense of personal meaning.

All of these transferences, of course, evoke corresponding countertransference. The therapist, intent on rescuing the patient from the horrible trauma he or she has experienced, may develop fantasies of omnipotence. Alternatively, the therapist may feel overwhelmed, angry, and helpless in response to the patient's seeming resistance to letting go of the trauma. Therapists themselves may feel traumatized by simply listening to the horror that the patient experienced. When the patient is particularly tenacious in holding on to memories of the trauma, the therapist may be filled with feelings of hopelessness and/or indifference.

Dissociative Disorders

In essence, dissociation represents a failure to integrate aspects of perception, memory, identity, and consciousness. Minor instances of dissociation, such as "highway hypnosis," transient feelings of strangeness, or "spacing out," are common phenomena in the general population. Extensive empirical evidence suggests that dissociation occurs especially as a defense against trauma. High frequencies of dissociative symptoms have been documented in the wake of firestorms (Koopman et al. 1994), earthquakes (Cardeña and

Spiegel 1993), war combat (Marmar et al. 1994), torture (Van Ommeren et al. 2001), and in those who have witnessed an execution (Freinkel et al. 1994). Dissociation allows individuals to retain an illusion of psychological control when they experience a sense of helplessness and loss of control over their bodies. Dissociative defenses serve the dual function of helping victims remove themselves from a traumatic event while it is occurring and delaying the necessary working through that places the event in perspective with the rest of their lives.

Trauma itself can be regarded as a sudden discontinuity in experience (Spiegel 1997). Dissociation during trauma leads to a discontinuous memory storage process as well. Approximately 25%–50% of trauma victims experience some kind of detachment from the trauma, whereas others have partial to total amnesia for the event (Spiegel 1991). These mental mechanisms allow victims to compartmentalize the experience so that it is no longer accessible to consciousness—it is as though the trauma did not happen to them. It is unclear why some people dissociate and others do not. An investigation of soldiers in survival training suggested that those who had reported threat to life in the past were more likely to dissociate under the stress of the training (Morgan et al. 2001). Another study (Griffin et al. 1997) suggested that physiological differences may have something to do with the propensity to dissociate.

Magnetic resonance imaging (MRI) studies of Vietnam veterans have demonstrated reduced right hippocampal volume in those who have PTSD compared with those who do not (Bremner et al. 1995). Depressed women who have been subjected to severe and prolonged physical and/or sexual abuse in childhood also have smaller hippocampal volume than control subjects (Vythilingam et al. 2002). The hippocampus is pivotal in the storage and retrieval of memory, leading some researchers to hypothesize that the memory difficulties associated with dissociation are linked to damage in that region (Spiegel 1997). Yehuda (1997) suggested that heightened responsiveness of the hypothalamic-pituitary-adrenal axis leads to an increase in the glucocorticoid receptor responsiveness that results in hippocampal atrophy. If the high degrees of stress associated with a traumatic event effectively shut down the hippocampus, then autobiographical memory for that event will be compromised (Allen et al. 1999). A common defensive response to trauma is dissociative detachment as a way of warding off intensive affects. Allen et al. (1999) pointed out that this detachment greatly narrows the individual's field of awareness, so that decreased recognition of the context may interfere with the process of elaborative encoding of the memory. Without the reflective thinking required for storage, the memory is not integrated into autobiographical narrative. These authors also suggested that dissociative detachment may involve a problem with cortical disconnectivity (Krystal et al.

1995) that interferes with higher cognitive functions such as language production. Rauch and Shin (1997) found that PTSD is associated with hypoactivity in Broca's area on positron emission tomography (PET) scans. The combination of hippocampal damage and hypoactivity in Broca's area suggests an impaired ability to cope with memories in lexical terms. Hence, dissociative phenomena may be helpful initially as a defense mechanism but may ultimately limit the brain's ability to cope with traumatic memories (Spiegel 1997).

Different patterns of neural activation appear to be related to different types of memory. Several authors (Brewin 2001; Driessen et al. 2004) have suggested a dual representation model of traumatic memories. Memories that are verbally accessible tend to be more independent from cues and situations, whereas traumatic memories appear to be uncontrollable, unconscious, and cue dependent. These latter memories, associated with the amygdala, the thalamus, and the primary sensory cortices, cannot easily be inhibited by the higher order brain areas, such as the cingulate, prefrontal, hippocampal, and language areas.

Genetic influences on vulnerability to dissociation are unclear. In a study of 177 monozygotic and 152 dizygotic volunteer twin pairs from the general population (Jang et al. 1998), subjects completed two measures of dissociative capacity taken from the Dissociative Experiences Scale (DES), a 28-item self-report questionnaire with established reliability and validity (Putnam 1991). The results showed that genetic influences accounted for 48% and 55% of the variance in scales measuring pathological and nonpathological dissociative experience, respectively. On the other hand, a similar twin study (Waller and Ross 1997) found no evidence for heritability.

The link between dissociation and childhood trauma has been established in a number of studies. In one investigation (Brodsky et al. 1995), among the 50% of subjects who had DES scores indicating pathological levels of dissociation, 60% reported a history of childhood physical and/or sexual abuse. In another study (Mulder et al. 1998) of 1,028 randomly selected individuals, 6.3% were found to have three or more frequently occurring dissociative symptoms, and these individuals had a fivefold higher rate of childhood physical abuse and a twofold higher rate of childhood sexual abuse.

Psychodynamic Understanding

Both repression and dissociation are defense mechanisms, and in both, the contents of the mind are banished from awareness. They differ, however, in the way the dismissed mental contents are handled. In the case of repression, a horizontal split is created by the repression barrier, and the material is

transferred to the dynamic unconscious. By contrast, a vertical split is created in dissociation so that mental contents exist in a series of parallel consciousnesses (Kluft 1991b). Moreover, the repression model has usually been invoked as a response to forbidden wishes, such as oedipal desires for a parent, rather than to external events. Hence, dissociation may be mobilized by trauma, whereas repression is activated by highly conflictual wishes (Spiegel 1991). Once mobilized, however, dissociation can be reactivated by wishes and desires.

In most cases of dissociation, disparate self-schemas, or representations of the self, must be maintained in separate mental compartments because they are in conflict with one another (Horowitz 1986). Memories of the traumatized self must be dissociated because they are inconsistent with the everyday self that appears to be in full control. One manager of a convenience store, for example, had dissociated a trauma involving anal rape during a holdup of the store because the image of himself as subjugated and humiliated in that situation was completely in conflict with his usual sense of himself as a manager who could "take charge" of all situations.

Dissociative amnesia and dissociative identity disorder have common psychodynamic underpinnings. Dissociative amnesia involves an inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. Dissociative identity disorder (DID), formerly known as multiple personality disorder, involves the disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. This disruption in identity must involve marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. Individuals with DID also have recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

All of these disorders are frequently misdiagnosed. In a typical case of DID, an average of 7 years of treatment elapses before the DID diagnosis is established (Loewenstein and Ross 1992; Putnam et al. 1986). Diagnosis of DID is particularly problematic because 80% of DID patients have only certain "windows of diagnosability" during which their condition is clearly discernible to clinicians (Kluft 1991b). Diagnostic rigor has been improved by the DES, which can be used effectively to identify high-risk patients. However, a definitive diagnosis requires the use of a structured interview such as the Structured Clinical Interview for Dissociative Disorders (Steinberg et al. 1991).

Dissociative amnesia may be the most common of the dissociative disorders (Coons 1998), but the diagnosis is often complicated by the fact that

almost all patients with this condition have additional psychiatric diagnoses. Moreover, unless specifically asked, many patients do not report periods of amnesia because of the very nature of amnestic episodes. The patient may well feel that everyone experiences memory gaps and that therefore the lost time periods are not remarkable or worth reporting to the clinician.

Allen et al. (1999) stressed the need to distinguish between the reversible memory failures associated with DID and dissociative amnesia and the irreversible memory discontinuities (during which autobiographical memories were not encoded and are therefore not retrievable) associated with dissociative detachment. There is a risk of overdiagnosing DID if all memory gaps are assumed to be attributable to dissociative amnesia, which entails recoverable memories.

Sensationalized cases of DID in the media do not reflect the fact that most patients with this disorder are highly secretive and prefer to conceal their symptoms. The separate dissociated self states, or "alters," are first deployed adaptively in an attempt on the part of the abused child to distance himself or herself from the traumatic experience. The alters soon gain secondary forms of autonomy, and a patient may hold a quasi-delusional belief in their separateness. The patient's personality actually consists of the sum total of all the personalities, of course, and Putnam (1989) clarified that alters are highly discrete states of consciousness that are organized around a prevailing affect, a sense of self and body image, a limited repertoire of behaviors, and a set of state-dependent memories. The old designation of multiple personality disorder was confusing, because the fundamental problem in the disorder is the state not of having more than one personality but of having less than one personality (Spiegel and Li 1997).

Population studies in Europe and North America have found that DID is a relatively common psychiatric disorder that occurs in about 1%–3% of the general population and up to perhaps 20% of patients in outpatient and inpatient treatment programs (Spiegel et al. 2011). Numerous studies using a variety of methodologies have documented a causal relationship between trauma and subsequent dissociation (Dalenberg et al. 2012). Individuals with DID show the highest rates of early life trauma when compared with all other clinical groups. Emotional, physical, and sexual abuse are common before the age of 5 in persons with this disorder. Although some people have questioned the prevalence of early sexual abuse, recent reports substantiate this alarmingly high rate. The National Institute of Justice and the Department of Defense supported a survey in 2010 known as the National Intimate Partner and Sexual Violence Survey. When the results were released, the study showed that in an international sample of 16,507 adults, one in five women reported being raped or being subjected to an attempted rape at some point in their lives. One in four had been beaten by an intimate part-

ner. One in seven had experienced severe violence at the hands of their partner, according to the survey (Rabin 2011). It is also important to stress that DID individuals have had high rates of adult traumatization, including rape and intimate partner violation (Simeon and Lowenstein 2009).

Most experts agree that trauma alone, however, is not sufficient to cause DID. Kluft (1984) proposed a four-factor theory of etiology: 1) the capacity to dissociate defensively in the face of trauma must be present; 2) traumatically overwhelming life experiences, such as physical and sexual abuse, exceed the child's adaptational capacities and usual defensive operations; 3) the precise forms taken by the dissociative defenses in the process of alter formation are determined by shaping influences and available substrates; and 4) soothing and restorative contact with caretakers or significant others is unavailable, so the child experiences a profound inadequacy of stimulus barriers.

One clear implication of the four-factor etiological model is that trauma is necessary but not sufficient to cause DID. At the risk of stating the obvious, not everyone who is abused as a child develops DID. Psychodynamic thinking has a significant contribution to make in furthering our understanding of the factors that lead to the full-blown syndrome. The concepts of intrapsychic conflict and deficit are relevant in DID just as they are in other conditions (Marmer 1991). Traumatic experiences may be due to a variety of conflicts around such issues as guilt over collusion with abusers or guilt over sexual arousal with an incestuous object.

Moreover, dissociation can occur in the absence of trauma in individuals who are highly fantasy prone and suggestible (Brenneis 1996; Target 1998). Hence, the presence of dissociation does not, in and of itself, confirm a history of early childhood trauma. Allen (2013) also notes that attachment research reveals intergenerational transmission of dissociative disturbances. Infant disorganization measured at 12 months is linked to subsequent dissociative pathology at the age of 19. He stresses that when there is a chronic impairment in caregiver responsiveness, the mother or caregiver cannot serve as the haven of safety that the infant seeks in times of danger. Hence, the infant may need to psychologically leave the situation by dissociating. In this regard early dissociation can represent an adaptive response to inescapable threat and/or danger where flight or fight is impossible. Moreover, early childhood dissociation can be considered a resiliency factor in DID in the sense that psychological sequestering of trauma memories appears to allow some aspects of normal development to occur (Brand et al. 2009).

Attachment theory has much to offer in furthering our understanding of the differential impact of childhood sexual abuse. In a study of 92 adult female incest survivors (Alexander et al. 1998), attachment style and abuse severity each appeared to make significant contributions to the prediction of post-trauma symptoms and distress as well as to the presence of personality

disorders. Abuse severity was not significantly related to adult attachment. In this sample, secure attachment was higher among women who had been abused by a father figure than among women who had been abused by someone other than a father figure. Only intrusiveness of thoughts of the abuse and avoidance of memories of the abuse, both classic PTSD symptoms, could be uniquely explained by abuse severity. The investigators concluded that the specific abuse experience and the relational context appeared to have distinct effects on the long-term functioning of incest survivors. Some of the most devastating and long-lasting effects of the incest appeared to be related to the family context and the meaning the patient attributed to intimate relationships overall.

The child's attachment is influenced almost entirely by the relationship with the parents and is relatively independent of genetic influence (Fonagy 2001; Fonagy et al. 1991a, 1991b). Expectant parents' mental models of attachment predict subsequent patterns of attachment between infant and mother and between infant and father. Each parent has an internal working model of relationships that appears to determine that parent's propensity to engender secure—as opposed to insecure—attachments in his or her children. Moreover, the mother's capacity to reflect on the mental state of another human being appears to be a predictor of the evolving relationship between infant and parent. Parents who can use constructs such as internal representations of attachment relationships are three to four times more likely to have secure children than are parents whose reflective capacity is poor.

This research on trauma and attachment may help us understand some of the difficulties faced by severely traumatized patients as a result of their reduced ability to think reflectively about themselves and about relationship experiences. These patients cope with the intolerable prospect of conceiving of the mental state of their tormentors by defensively disrupting the depiction of feelings and thoughts (Fonagy 1998). Attachment research also confirms Kluft's fourth factor in that it suggests the encouraging possibility that abused children who can establish mentalization, or the capacity to understand the representational nature of one's own and others' thinking, often through the assistance of a caring adult, might avoid developing severe psychopathology.

Self-destructive behaviors in DID patients cry out for psychodynamic explanation. Revictimization is a pattern of behavior that DID patients share with other victims of incest and childhood abuse (Browne and Finkelhor 1986; van der Kolk 1989). Rape, prostitution, and sexual exploitation by therapists all occur at higher rates with incest victims than with others. Some gender differences exist in this pattern of re-creation of victimization. Abused men and boys tend to identify with their aggressors and later victimize others as adults, whereas women who were abused become attached to

abusive men and allow themselves and their offspring to be victimized further (Carmen et al. 1984).

Often, children who grow up in families in which parents abuse them do not have soothing caretakers to whom they can turn to mitigate the trauma. In the absence of such persons, the victims turn to their tormentors (Allen 2013), and this pattern of object relationships persists into adulthood when they look for partners who will continue the "dance" they established as children. Abused children come to believe that an abusive parent is better than no parent at all. The predictability of such relationships helps them defend against the threat of abandonment: the devil one knows is often better than the devil one does not know. The repetition of traumatic relationships is also an example of an attempt to actively master passively experienced trauma. The victims seek to have more control over what was completely outside their control as children.

The intergenerational dimensions of sexual abuse are well known (Carmen et al. 1984; Gelinas 1986; van der Kolk 1989). Parents who abuse their children tend to be abuse victims themselves. In many cases these parents are outraged that their innocence was taken away from them at such a tender age. They may experience profound envy of their own children's innocence, so through the abuse of their children, they enviously attack and spoil what was similarly taken from them (Grotstein 1992).

When DID patients recall their childhood sexual abuse, they often blame themselves for the events that occurred to them. As children they frequently held on to the belief that they received such punishment because they were bad children who had misbehaved. Although to some extent this shame and guilt can be explained by introjective identifications with "bad" parents, the self-blame can also be understood as a desperate attempt to make sense out of a horrific situation. If they maintain some capacity to mentalize, they can make sense of the situation by convincing themselves that their parents are basically good people who have their children's interests at heart. The fact that their parents treat them the way they do must reflect that they are bad and deserve it. When clinicians try to persuade these patients that what happened was not their fault, the patients often feel that they are misunderstood. There may be an adaptive aspect to this posture in abuse victims, because the locus of control is perceived as internal rather than external, and as a result, there is a diminished sense of helplessness (van der Kolk 1989).

There is a general tendency within the DID literature to stress the ways in which dissociation is different from splitting. Young (1988) noted that alters tend not to be polarized around contradictory ego states but rather have many overlapping characteristics. Marmer (1991) argued that whereas in DID the self is split more than the objects, the reverse is true in borderline personality disorder. Kluft (1991d) pointed out that dissociation differs

from splitting in three ways: first, it is associated with a psychobiological switching process; second, the different states that result have significantly different psychophysiological characteristics; and finally, amnestic barriers are often constructed between alters. Davies and Frawley (1992) distinguished dissociation from splitting on the basis that the former involves a cleavage of ego states, whereas the latter involves a division between a good object and a bad object—a point also made by Kluft (1991a).

A careful examination of the mechanisms of dissociation and splitting suggests that they have both similarities and differences (P. Lerner, "Some Thoughts on Dissociation," unpublished manuscript, 1992). Both are characterized by active separation and compartmentalization of mental contents. Both are used defensively to ward off unpleasant experiences and affects. Both are disruptive to the formation of a smooth and continuous sense of self. On the other hand, dissociation and splitting differ in terms of which ego functions are disrupted. Kernberg (1975) made it clear that impulse control and tolerance for anxiety and frustration are specifically impaired in splitting. By contrast, in dissociation, memory and consciousness are affected. Finally, dissociation is a broader mechanism than splitting—a variety of divisions occur in dissociation, not simply separations into polarized extremes of affective valence.

The literature on dissociation in DID has focused almost exclusively on the divisions in the self while taking little notice of the corresponding division of objects linked to the self representations. Fairbairn (1940/1952, 1944/1952) was the first to stress that the child internalizes not an object but an object relationship. Davies and Frawley (1992) made note of this dimension when they commented that dissociation is not only a defense but also a process that protects and preserves the entire internal object world of the abused child in split-off form. Citing Fairbairn's thinking, Grotstein (1992) reached similar conclusions:

> All mental cleavages are based ultimately on the divisions of perceptions and experiences in regard to objects—and the selves related to each of them. Thus, the dissociation that typifies the multiple personality disorder constitutes, from this point of view, a division of the ego into vertical splits based upon corresponding vertical splits in one's incompatible experiences of the object. (p. 68)

One of the practical implications of this conceptualization is that each alter presents a self in relationship to a fantasied internal object. Brenner (2001) suggested that these constellations of self, internal self, and object relationships may also correspond to different levels of character pathology. He postulated a continuum of these characterological levels, with the lower level dissociative character representing the classic "multiple personality"

patient. An intermediate level of dissociative character has a more integrated set of intrapsychic functions. He also noted that there is a higher level of dissociative character in which the altered states of consciousness result in minimal disturbance of identity.

Treatment Considerations

The psychotherapy of patients with DID and other dissociative disorders is generally long and arduous. There is no definitive brief psychotherapy for these conditions. To be successful, psychotherapy of DID must begin with the establishment of a firm and secure treatment frame. Because of the history of childhood violations in these patients, such details as length of session, payment of fees, appointment times, and use of words rather than touch must all be established from the beginning. A strong therapeutic alliance is crucial for the treatment to proceed, and this may be facilitated by empathizing with the patient's subjective experience during the opening phase of the therapy.

A common theme in patients with childhood trauma, especially incest victims, is difficulty determining who is doing what for whom. For example, a daughter who has had an incestuous relationship with her father begins to see her role as that of gratifying the father's needs. Her father may rationalize that he is teaching something to his daughter. In addition, the daughter may feel that she is special to her father because he has singled her out as the object of his desire. At the same time, she may be terribly conflicted about such feelings. She expects that parents should look after the needs of their children, but her experience is the reverse of that. She feels like she must attune herself to the needs of her parents. She will then enter psychotherapy with the same sense of confusion: Who is doing what for whom in the therapeutic setting?

Such a patient would understandably be skeptical of the idea that the therapist is there to be helpful or to care about her. There may be distrust about what will really happen if she asserts herself. She may simply try to figure out what the therapist wants and attempt to meet the therapist's needs instead of her own.

The therapist's major thrust must be to engage the patient's sense of agency. In other words, the therapist must help the patient to recognize that he or she is actively re-creating past patterns in the present. In a recent reconsideration of Frau Emmy von N, the subject of Freud's first published case of hysteria, Bromberg (1996) made the following observation: "We do not treat patients such as Emmy to cure them of something that was done to them in the past; rather, we are trying to cure them of what they still do to themselves and to others in order to cope with what was done to them in the past" (p. 70).

Interpretive interventions must be used sparingly with DID patients, particularly in the early phases of the therapy. Traumatized patients often experience interpretations as a challenge to their sense of reality (Gabbard 1997). Although interpretation of conflict-based pathology revolves around a concealed meaning that the therapist attempts to reveal to the patient, severely traumatized patients often feel retraumatized and invalidated by that approach. Killingmo (1989) recommended affirmative interventions to remove doubt in such patients. Affirmation that patients have the right to feel what they are feeling may serve to build a solid alliance, thereby creating a climate in which interpretations can be heard and valued.

There is a broad consensus among clinicians who write about the treatment of DID that a solid grounding in the principles of psychodynamic psychotherapy is essential for successful treatment (Allen 2001; Ganaway 1989; Kluft 1991b; Loewenstein and Ross 1992; Marmer 1991). Simple catharsis and abreaction will result in neither integration nor recovery. In fact, repeating the trauma over and over again in psychotherapy may even reinforce the preoccupation and fixation of the patient with the trauma (van der Kolk 1989). Without proper understanding of psychodynamic principles, therapy may become stalemated in a state of "status abreacticus" (Ganaway 1992).

The current state-of-the-art psychotherapy for DID is a phasic treatment involving stages of treatment based on ratings of interventions by experts in the field (Brand et al. 2014). In the first phase the therapist hopes to achieve a sense of safety and stability in the patient. The second stage involves the development of a detailed narrative and the processing of traumatic memories if the patient has the psychological resources to engage in that work. The third phase is geared toward reintegration, that is, relegating traumatic memories to a status of "bad memories" from the past and a concerted effort to live well in the present. Developing a better adaptation to life is the foremost goal. Throughout the treatment the patient with DID should be held accountable for all the behaviors, recognizing that the patient is made up of all the self states rather than viewing only one as the "real person" (Putnam 1997). Hence, all the self states are treated in an even-handed way by therapists. An overarching aspect of the phasic treatment is attention to developing a therapeutic alliance and repairing ruptures in it throughout all phases on the basis of the principle that the best predictor of outcome is the therapeutic relationship. Grounding techniques, such as focusing on the senses; containment techniques, including self-hypnosis and imagery to control intrusiveness of material; reaffirming statements; relaxation training; and trauma-focused cognitive work to change cognitions are all part of the approach.

Treatment has been studied using a prospective naturalistic design. A study titled "Treatment of patients with dissociative disorders" (TOP DD) prospectively assessed outcomes from 280 patients with DID or dissociative

disorders not otherwise specified using 292 therapists from 19 countries at four time points over 30 months of treatment (Brand et al. 2014). The results were encouraging. Even the patients with the highest levels of dissociation, as well as the most severe depression, showed significant improvements in symptoms over the 30-month period. Self-injurious behaviors, suicide attempts, and revictimization events decreased over the time of treatment. Only 1.1% showed worsening at more than one data collection point. In summary, the TOP DD study demonstrated that adaptive functioning and a wide range of symptoms improve, while the necessity of utilizing higher levels of care decreases with effective treatment.

Countertransference Dimensions

Few disorders create countertransference reactions of the intensity witnessed with DID patients. Ganzarain and Buchele (1988) pointed out that at home, incest victims are often treated as either favorites or objects of violence and sadism. Similarly intense reactions, polarized in the same directions, occur in the treatment of adult DID patients. Much of the emotional reaction to these patients is linked to a dialectic involving belief versus skepticism. At one extreme, many mental health professionals still do not believe that DID is a bona fide psychiatric disorder. Some clinicians view the disorder as iatrogenically created by gullible therapists who misuse hypnosis.

At the other extreme, some therapists uncritically believe everything their DID patients tell them, no matter how outlandish. They become fascinated by the condition and completely lose track of professional boundaries. They attempt to love the patient back to health and to be a better parent than the original parents. They may treat the patients with a "chimney sweeping" mentality of endlessly forcing abreaction of traumatic memories with the naive expectation that all will be well once the patient is "cleaned out." The following vignette illustrates this pattern:

> Ms. P was a 26-year-old woman with DID who was referred to a tertiary care dissociative disorders unit after having been in psychotherapy for 1 year with a male therapist who reported no improvement in the patient's suicidality and self-mutilation despite treatment. He had seen the patient 5–6 hours per week throughout the year of therapy. When the patient required hospitalization, he spent hours with the patient in the security of a seclusion room abreacting memories of past trauma. He had allowed the patient's bill to accumulate to several thousand dollars because he had not asked Ms. P to pay for several months. He also indicated that Ms. P and he were writing a book together about the treatment.
>
> After Ms. P's hospitalization on the dissociative disorders unit to which she had been referred, she began to reveal horrific stories about satanic cult abuse in her past. She would provide grisly details of human sacrifice and re-

act with an affective display that was compelling to watch. She "recalled" that she had been a "breeder" for the cult so they would have babies to sacrifice. She reported that after giving birth to the babies, the cult members would grind them up in a meat grinder and then mix them in with the soil used in their garden so that corroborating evidence of the murders could not be found. When Ms. P was sent for a routine gynecological exam, it was discovered that she had in fact never delivered a child.

The doctor in charge of Ms. P's treatment called her previous therapist to explain these findings. However, the therapist discounted the gynecological evidence and said it was of paramount importance for the staff to believe Ms. P. He said if the staff did not believe her reports, they were simply repeating the past trauma when adults did not believe her tales of abuse.

The question of whether memories of trauma are accurate may become polarized into an "either/or" controversy that ignores the broad middle ground where well-trained psychodynamic clinicians reside and practice. Most patients who were abused have clearly remembered memories that are lifelong, and in these cases, the therapist can empathize with their experiences and explore the specific personal meanings of the trauma.

When memories are recovered during the course of therapy, the therapist and the patient simply do not know how accurate those memories are. Extensive research has suggested that memory is definitely not a fixed record of experience, inextricably embedded in the mind in the way that an event is recorded on film. Indeed, new protein synthesis appears to occur each time a memory of an experience is retrieved (LeDoux 2002). The recall of a memory is more like a theatrical production in which each run-through of the play is somewhat different from the previous one as the play evolves. There is no such thing as pure recapitulation or revival of the past, only reconstructions based on individual meanings that the patient attributes to the event (Edelman 1992; Modell 1996; Novick and Novick 1994).

Memories may be true but inaccurate (Barclay 1986). As Spiegel and Scheflin (1994) suggested, a memory may have false details but still derive from a real incident. Perception and memory are always active processes of construction. We cannot imagine a memory that is not influenced by the observer. Hence, there is a wide spectrum of accuracy in memories that we see clinically, ranging from totally false memories induced by therapists who are either poorly trained or unscrupulous to reasonably accurate memories in which the details are more or less intact (see Table 10–1). Between these two extremes is a continuum involving varying degrees of accuracy (Allen 1995).

In his 1914 paper "Remembering, Repeating and Working-Through," Freud noted that what the patient cannot remember is repeated in the analytic setting (Freud 1914/1958). He was referring to patterns of unconscious, internalized object relations that unfold before the analyst's eyes because the patient does not recall them and cannot speak about them.

TABLE 10–1. The spectrum of accuracy in memory of trauma

Actual trauma history
Continuously/clearly remembered with corroboration
Delayed/fragmentary memory with corroboration
Continuously/clearly remembered without corroboration
Delayed/fragmentary memory without corroboration
Exaggerated/distorted memory
No trauma history
False memory—patient constructed
False memory—therapist suggested

Source. Based on Allen 1995.

The distinctions between implicit versus explicit and procedural versus declarative memory systems are relevant to Freud's observations (Clyman 1991; Squire 1992). As described in Chapter 1, explicit declarative memory involves autobiographical narratives of one's life. When trauma occurs before the age of 3 or 4 years, it may not be remembered in the explicit memory system but may be encoded in the implicit procedural memory system. Trauma occurring after 4 years of age is usually retained as explicit memory to some extent, although research suggests that some adults are unable to remember childhood sexual abuse or other traumas for long periods of time (Allen 2001; Brown et al. 1998; Williams 1994).

Traumatic reenactments appear to be driven by implicit procedural memory (Siegal 1995). Included in this category would be many of the transference-countertransference enactments that Freud was referring to when he stated that memories are repeated rather than verbalized. In other words, unconscious internal object relationships are stored in the implicit memory system and appear in the therapy in the way the patient relates to the therapist (Gabbard 1997; Target 1998). Hence, the kind of data that unfold in the psychological drama between therapist and patient are not readily available through other means. Through projection and introjection between therapist and patient, the therapist has a unique perspective on the patient's past and internal world. Although the therapist cannot know with certainty that the implicit memories unfolding in the relationship between therapist and patient provide an accurate glimpse of what happened in the patient's childhood, such memories can at least reveal what was experienced by the child at the time, including the child's fantasies about the interactions.

With this new understanding of memory, we now consider an archaeological search for convincing relics of the trauma from the buried past to be

a misguided strategy in therapy. This approach is often a form of countertransference collusion with the patient to avoid the patient's direct expression of aggression or rage at the therapist and the therapist's identification with the abusive introject, a phenomenon I have called "disidentification with the aggressor" (Gabbard 1997, p. 7). Use of such an approach may also pressure the patient to come up with abuse memories that in fact may reflect the patient's unconscious experience of being intruded upon by the therapist (Brenneis 1997). Another difficulty with pressuring the patient to recover memories is that in cases of dissociative detachment, the memory may never have been encoded in the first place, so that what is retrieved is a confabulated or constructed memory related to the patient's effort to please the therapist by producing meaningful material for the treatment.

Moreover, a change in autobiographical or explicit declarative memory does not appear to be necessary for therapeutic improvement. The therapist observes and interprets the unconscious enactments fueled by equally unconscious patterns of internal object relations. Memories consistent with these patterns may be secondarily activated, but their return is best viewed as merely an epiphenomenon, and their accuracy is impossible to ascertain (Fonagy and Target 1997; Gabbard 1997). What appears to be critical is the change in patterns of living with oneself and others that results from the patient's insight about these previously unconscious patterns. In addition, there are changes that occur unconsciously as the interaction with the therapist is internalized.

The therapist must make clear to the patient that recovery of traumatic memories is not the goal of the psychotherapy. The memory dysfunction typical of patients with dissociative disorders actually makes them less-than-ideal subjects for therapy aimed at recovering memories. A more reasonable goal is to help them recover normal mental functions, particularly the capacity to reflect and mentalize, so that they can develop a more coherent representation of self and others. In the context of a strong attachment relationship to the therapist, the traumatized patient can benefit from the therapist's capacity to reflect on what is happening between them. Ultimately, patients may internalize the therapist's reflective process and become able to bring dissociated aspects of themselves back into awareness so that they experience a greater sense of continuity. Integration of the alters may be possible only for some patients with DID.

The therapist must avoid the role of "arbiter of historical truth." What people remember is always a complex mixture of fantasy and reality (Arlow 1969; Gediman 1991; Grotstein 1992). Therapists must listen to the material with a nonjudgmental attitude of curiosity without being coerced into declaring that what they have heard is 100% accurate or totally false. Kluft (1988) cautioned that clinicians must avoid "the expression of fascination,

surprise, excitement, dismay, belief, disbelief, or the voicing of any opinion that could cause the alters to feel the need to demonstrate their authenticity" (p. 53).

A useful way to look at the transference-countertransference developments in the psychotherapy of DID patients is to conceptualize them as episodes in an unfolding drama involving four principal characters: a victim, an abuser, an idealized omnipotent rescuer, and an uninvolved other (Davies and Frawley 1992; Gabbard 1992). These characters oscillate in various complementary pairings between patient and therapist through the transference-countertransference enactments that develop in the psychotherapy. The first three characters in the cast—the victim, the abuser, and the idealized omnipotent rescuer—interact in a predictable pattern that represents a convergence of countertransference in the narrow sense and countertransference in the broad sense via projective identification. When a history of victimization emerges in a patient, something powerful tugs on the heartstrings of therapists that urges them to somehow try to repair the damage by becoming the good parents that the patient never had.

Most DID patients have not had the benefit of growing up with generational boundaries and limits enforced by effective, caring parents. They often experience the professional boundaries of the therapeutic situation as a cruel form of withholding. They may demand demonstrations of caring that involve extended sessions, physical contact, self-disclosure from the therapist, and round-the-clock availability. If therapists begin to "go the extra mile" to gratify these requests, their efforts are doomed to failure. The attempt to become a parental substitute bypasses the patient's need to mourn and raises false hopes that a parental relationship is available if only the patient can find the right person.

When a therapist attempts to gratify a patient's escalating demands for evidence that the therapist cares, the patient's sense of entitlement is activated. Treatment of most patients with DID sooner or later reveals their underlying conviction that they are entitled to compensation in the present for the abuse they experienced in the past (Davies and Frawley 1992). As the demands further escalate, the therapist may quickly develop a feeling of being tormented. Through processes of introjective and projective identification, the cast of characters has changed in such a way that the therapist has become the victim and the patient has become an abuser. Abusive or malevolent introjects residing within the patient have taken hold while the victim-self of the patient is projected onto the therapist. Moreover, therapists may create a fertile field for this identification with the patient's/victim's self representation as a result of guilt feelings related to their growing resentment and hatred of the patient. Patients may sense this development and accuse the therapist of not really caring. In an effort to deny their feelings of resent-

ment at being asked to do too much and to go too far, therapists try even harder to prove that their motives are pure. At such moments therapists may secretly feel that they have been "found out" and react by trying to mask their irritation. An acknowledgment of one's limits may be the most therapeutic way to manage one's countertransference feelings when things reach this point (Gabbard 1986; Gabbard and Wilkinson 1994).

The third act of the drama unfolds in certain instances when the escalating pattern of increasing demands by the patient is accompanied by increasing efforts by the therapist to gratify those demands. At the height of their exasperation with the failure of all therapeutic efforts, therapists may resort to drastic boundary crossings with the patient that in effect repeat the childhood abuse. The therapist then has become the abuser with the patient once again in the role of victim. The most tragic—and, unfortunately, all-too-frequent—manifestation of this third paradigm is overt sexual contact between therapist and patient. Other common examples include sadistic verbal abuse of the patient, attempts to provide nurturance by sitting the patient on the therapist's lap and "re-parenting" the patient, taking the patient on family outings with the therapist's family, and so forth. In such situations the therapist's rage at being thwarted is often completely disavowed. What began as a rescue effort has ended up as a reenactment of exploitation and abuse.

Many patients with DID have a form of learned helplessness in which they believe that no effort on their part can change their fate. They assume that when trapped, they have no recourse. These patients have no sense of agency or efficacy to call upon. In this sense they are what Kluft (1990) termed "sitting ducks" for all forms of abuse and boundary violations by therapists who use their patients to gratify their own needs.

The three roles of victim, abuser, and idealized omnipotent rescuer are the most dramatic and obvious manifestations of the introjective-projective processes at work in the psychotherapy of DID patients. The fourth role, the uninvolved other, shows itself in a somewhat more subtle way (Gabbard 1992). Patients will often perceive this persona in the therapist's silence, which is interpreted as indifference and rejection. In response to this perception of indifference, the patient may feel a sense of nonbeing—described by Bigras and Biggs (1990) as "negative incest"—a deadness or emptiness related to the absent mother who made no attempt to intervene in the incestuous relationship between her husband and her daughter.

The deadness or emptiness experienced by the patient may foster complementary feelings of helplessness and despair in the psychotherapist. There may be long periods in the psychotherapy when the patient remains aloof and distant from the therapist and evokes feelings of deadness or nonbeing in the countertransference (Levine 1990; Lisman-Pieczanski 1990).

The following excerpt from a psychotherapy session with a DID patient depicts this countertransference identification with the uninvolved mother:

Ms. Q: If I could just leave this damn hospital, everything would be fine. My only problem is I hate to be confined like this, and it makes me want to mutilate.

Therapist: But I wonder if confinement is really your only problem. You certainly mutilated a great deal before you were admitted to the hospital.

Ms. Q: But I need to see my children and my husband. Don't you understand? They won't let them visit me here.

Therapist: The last time they visited you here, you ended up making a serious suicide attempt.

Ms. Q (*blandly*): I wanted to cut the artery in my wrist and end everything.

Therapist: Well, then, I can imagine that the staff would be reluctant to have you leave the structure and protection of the hospital.

Ms. Q: I need to give it a try out of here for a while. I think if I could just be with my family outside the hospital, then I'd be fine.

Therapist: What would you do if anxiety came over you and you felt like mutilating?

Ms. Q (*with utter seriousness*): I could have a beer or two to settle myself down.

Therapist: It's very important that you see that your problems are not external. You carry your problems within you wherever you go, and no matter whether you're confined to a hospital or home with your family, you'll still have them. Until you make some effort to integrate and face the painful experiences from the past, you'll continue to mutilate yourself and wish to commit suicide.

Ms. Q: I don't want to face the pain of integrating the personalities. It would be unbearable.

Therapist: But you're in considerable pain now. Can it be that much worse?

Ms. Q (*blandly*): I don't know, but I don't want to find out.

As the therapist continued to get nowhere with this line of reasoning, he found himself getting increasingly drowsy. Associated with the sleepy feeling, he felt as though he were withdrawing farther and farther away from the patient. He began looking at the clock and wishing the time was up. He found himself thinking about what he would do later in the day. He even felt that he no longer really cared if the patient got better or not. The patient also seemed to be drifting further and further away from him. As he observed this remarkable lapse in empathic attunement, it dawned on the therapist that he was becoming the absent, uninvolved mother of her childhood. His efforts to help had been thwarted, and he had a deep sense of despair and hopelessness about anything ever changing. He wondered if the patient's mother, too, had felt that way when she realized that she was forever excluded from the bond between her daughter and her husband and felt powerless or helpless to change anything about it.

Countertransference responses such as the one described by Ms. Q's therapist may also reflect an empathic identification with a sense of nonbeing at the core of the patient's self in response to the distant maternal identification in the patient (Gabbard 1992). There comes a time in the psychotherapy of DID patients when the demandingness of the patient is so overwhelming that therapists find themselves wishing the patient would disappear or go elsewhere for treatment. In such reactions an identification with the uninvolved mother is easily detected, and therapists must be mindful that such unconscious collusions may lead unwittingly to suicide attempts on the part of the patient.

The primitive states of psychological deadness depicted in this transference-countertransference paradigm may relate to profound maternal deprivation that severely compromised the infant's developing sense of self. In the absence of the maternal provision of soothing sensory experience, the infant may not establish a secure feeling of sensory boundedness. The self-mutilation so common in patients with DID can be understood as a way of reestablishing boundedness at the skin border to deal with anxiety about losing intactness of the ego boundary. Ogden (1989) characterized this mode of generating experience as the *autistic-contiguous position.* In this primitive state the process of attributing meaning to experience ceases. Therapists may experience DID patients as so imprisoned in such a primitive state that they are completely unreachable. Therapists may then be imbued with a sense of hopelessness in dealing with the patient's anxiety about lack of body integrity secondary to deprivation of close sensory experiences with mother.

Hospital Treatment

Depending on their level of ego organization and the degree of comorbidity, many patients with DID will require hospitalization at some point in the course of psychotherapy (Kluft 1991c).

Patients with DID who enter general psychiatry units often find themselves in the role of the classic "special" patient (Burnham 1966; Gabbard 1986). They are regarded both by staff members and by other patients as having special relationships with their psychotherapists and often become scapegoated as a result. Skeptical staff members will begin arguments about what name to use with the patient, the validity of the abuse history, whether the patient is responsible for his or her actions, and myriad other issues. Matters may be made worse if other patients in milieu groups react with disbelief and contempt when a DID patient denies behavior that others have witnessed.

Kluft (1991c) provides several helpful guidelines. A contractual agreement must be made with the patient at the beginning of the stay stipulating

consent to respond to his or her legal name when addressed by it in the milieu. The patient should be told that staff cannot be expected to respond to different alters in different ways when they emerge on the unit. Only the individual therapist will address the separate alters. A patient who cannot make a contract on behalf of all alters must be structured at the level of the most dangerous or self-destructive alter. This agreement avoids the inevitable confusion in staff members about privileges and responsibilities given the variability of functioning of the different alters. Kluft (1991c) also suggests that nursing staff must continually explain rules and policies to patients, as some alters will not be familiar with them.

References

Alexander PC, Anderson CL, Brand B, et al: Adult attachment and long-term effects in survivors of incest. Child Abuse Negl 22:45–61, 1998

Allen JG: The spectrum of accuracy in memories of childhood trauma. Harv Rev Psychiatry 3:84–95, 1995

Allen JG: Traumatic Relationships and Serious Mental Disorders. New York, Wiley, 2001

Allen JG: Mentalizing in the Development and Treatment of Attachment Trauma. London, Karnack, 2013

Allen JG, Console DA, Lewis L: Dissociative detachment and memory impairment: reversible amnesia or encoding failure? Compr Psychiatry 40:160–171, 1999

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Arlow JA: Fantasy, memory, and reality testing. Psychoanal Q 38:28–51, 1969

Barclay CR: Schematization of autobiographical memory, in Autobiographical Memory. Edited by Rubin DC. New York, Cambridge University Press, 1986, pp 82–99

Bigras J, Biggs KH: Psychoanalysis as incestuous repetition: some technical considerations, in Adult Analysis and Childhood Sexual Abuse. Edited by Levine HB. Hillsdale, NJ, Analytic Press, 1990, pp 173–196

Binder EB, Bradley RG, Liu W, et al: Association of FKBP5 polymorphisms and childhood abuse with post-traumatic stress disorder symptoms in adults. JAMA 299:1291–1305, 2008

Bradley R, Greene J, Russ E, et al: A multidimensional meta-analysis of psychotherapy for PTSD. Am J Psychiatry 162:214–227, 2005

Brand BL, Classen CC, Lanius RA, et al: A naturalistic study of dissociative identity disorder and dissociative disorder not otherwise specified patients treated by community clinicians. Psychol Trauma 1:153–171, 2009

Brand BL, Loewenstein RJ, Lanius RA: Dissociative identity disorder, in Gabbard's Treatments of Psychiatric Disorders, 5th Edition, Washington, DC, American Psychiatric Publishing, 2014

Bremner JD, Randall P, Scott TM, et al: MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. Am J Psychiatry 152:973–981, 1995

Brenneis CB: Multiple personality: fantasy proneness, demand characteristics, and indirect communication. Psychoanalytic Psychology 13:367–387, 1996

Brenneis CB: Recovered Memories of Trauma: Transferring the Present to the Past. Madison, CT, International Universities Press, 1997

Brenner I: Dissociation of Trauma: Theory, Phenomenology, and Technique. Madison, CT, International Universities Press, 2001

Breslau N: The epidemiology of trauma, PTSD, and other post trauma disorders. Trauma Violence Abuse 10:198–210, 2009

Brewin C: Memory processes in posttraumatic stress disorder. Int Rev Psychiatry 13: 159–163, 2001

Brodsky BS, Cloitre M, Dulit RA: Relationship of dissociation to self-mutilation and childhood abuse in borderline personality disorder. Am J Psychiatry 152:1788–1792, 1995

Brom D, Kleber RJ, Defares PB: Brief psychotherapy for post traumatic stress disorders. J Consult Clin Psychol 57:607–612, 1989

Bromberg PM: Hysteria, dissociation, and cure: Emmy von N revisited. Psychoanalytic Dialogues 6:55–71, 1996

Brown D, Scheflin AW, Hammond DC: Memory, Trauma Treatment, and the Law. New York, WW Norton, 1998

Browne A, Finkelhor D: Impact of child sexual abuse: a review of the research. Psychol Bull 99:66–77, 1986

Burnham DL: The special-problem patient: victim or agent of splitting? Psychiatry 29:105–122, 1966

Cardeña E, Spiegel D: Dissociative reactions to the Bay Area earthquake. Am J Psychiatry 150:474–478, 1993

Carmen EH, Reiker PP, Mills T: Victims of violence and psychiatric illness. Am J Psychiatry 141:378–379, 1984

Clyman RB: The procedural organization of emotions: a contribution from cognitive science to the psychoanalytic theory of therapeutic action. J Am Psychoanal Assoc 39(suppl):349–382, 1991

Coons PM: The dissociative disorders: rarely considered and underdiagnosed. Psychiatr Clin North Am 21:637–648, 1998

Copeland WE, Keeler G, Angold A, et al: Traumatic events and post-traumatic stress in childhood. Arch Gen Psychiatry 64:577–584, 2007

Dalenberg CJ, Brand BL, Gleaves DH, et al: Evaluation of the evidence for trauma and fantasy models of dissociation. Psychol Bull 138:550–588, 2012

Davidson JRT: Recognition and treatment of post-traumatic stress disorder. JAMA 286:584–587, 2001

Davies JM, Frawley MG: Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. Psychoanalytic Dialogues 2:5–36, 1992

Driessen M, Bedlo T, Mertens, N et al: Posttraumatic stress disorder and fMRI activation patterns in traumatic memory in patients with borderline personality disorder. Biol Psychiatry 55:603–611, 2004

Edelman G: Bright Air, Brilliant Fire: On the Matter of the Mind. New York, Basic Books, 1992

Fairbairn WRD: Schizoid factors in the personality (1940), in Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952, pp 3–27

Fairbairn WRD: Endopsychic structure considered in terms of object-relationships (1944), in Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952, pp 82–136

Fonagy P: An attachment theory approach to treatment of the difficult patient. Bull Menninger Clin 62:147–169, 1998

Fonagy P: Attachment Theory. New York, Other Press, 2001

Fonagy P, Target M: Perspectives on the recovered memories debate, in Recovered Memories of Abuse: True or False? Edited by Sandler J, Fonagy P. London, Karnac Books, 1997, pp 183–216

Fonagy P, Steele M, Steele H, et al: The capacity for understanding mental states: the reflective self in parent and child and its significance for security of attachment. Infant Ment Health J 12:201–218, 1991a

Fonagy P, Steele H, Steele M: Maternal representations of attachment during pregnancy predict the organization of infant–mother attachment at one year of age. Child Dev 62:891–905, 1991b

Forbes D, Creamer M, Bisson JI, et al: A guide to guidelines for the treatment of PTSD and related conditions. J Traumatic Stress 23:537–552, 2010

Freinkel A, Koopman C, Spiegel D: Dissociative symptoms in media eyewitnesses of execution. Am J Psychiatry 151:1335–1339, 1994

Freud S: Remembering, repeating and working-through (further recommendations on the technique of psycho-analysis II) (1914), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 145–156

Gabbard GO: The treatment of the "special patient" in a psychoanalytic hospital. International Review of Psychoanalysis 13:333–347, 1986

Gabbard GO: Commentary on "Dissociative processes and transference-countertransference paradigms" by Jody Messler Davies and Mary Gail Frawley." Psychoanalytic Dialogues 2:37–47, 1992

Gabbard GO: Challenges in the analysis of adult patients with histories of childhood sexual abuse. Canadian Journal of Psychoanalysis 5:1–25, 1997

Gabbard GO, Wilkinson SM: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press, 1994

Ganaway GK: Historical versus narrative truth: clarifying the role of exogenous trauma in the etiology of DID and its variants. Dissociation 2:205–220, 1989

Ganaway GK: Hypnosis, dissociation and multiple personality disorder: a psychodynamic clinician's perspective. Paper presented at the annual meeting of the Society of Clinical and Experimental Hypnosis, Washington, DC, October 1992

Ganzarain RC, Buchele BJ: Fugitives of Incest: A Perspective From Psychoanalysis and Groups. Madison, CT, International Universities Press, 1988

Gediman HK: Seduction trauma: complemental intrapsychic and interpersonal perspectives on fantasy and reality. Psychoanalytic Psychology 8:381–401, 1991

Gelinas DJ: Unexpected resources in treating incest families, in Family Resources: The Hidden Partner in Family Therapy. Edited by Karpel MA. New York, Guilford, 1986, pp 327–358

Griffin MG, Resick PA, Mechanic MB: Objective assessment of peritraumatic dissociation: psychophysiological indicators. Am J Psychiatry 154:1081–1088, 1997

Grotstein JS: Commentary on "Dissociative processes and transference-countertransference paradigms" by Jody Messler Davies and Mary Gail Frawley." Psychoanalytic Dialogues 2:61–76, 1992

Hendin H, Haas AP: Suicide and guilt as manifestation of PTSD in Vietnam combat veterans. Am J Psychiatry 148:586–591, 1991

Horowitz MJ: Stress Response Syndromes, 2nd Edition. Northvale, NJ, Jason Aronson, 1986

Jang KL, Paris J, Zweig-Frank H, et al: Twin study of dissociative experience. J Nerv Ment Dis 186:345–351, 1998

Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Kessler RC, Sonega A, Bromet E, et al: Post traumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry 52:1048–1060, 1995

Kessler RC, Berglund P, Delmer O, et al: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Arch Gen Psychiatry 62:593–602, 2005

Killingmo B: Conflict and deficit: implications for technique. Int J Psychoanal 70:65–79, 1989

Kleindienst K, Limberger MF, Ebner-Priemer UW, et al: Dissociation predicts poor response to dialectical behavior therapy in female patients with borderline personality disorder. J Pers Disord 25:432–447, 2011

Kluft RP: Treatment of multiple personality disorder: a study of 33 cases. Psychiatr Clin North Am 7:9–29, 1984

Kluft RP: The phenomenology and treatment of extremely complex multiple personality disorder. Dissociation 1:47–58, 1988

Kluft RP (ed): Incest-Related Syndromes of Adult Psychopathology. Washington, DC, American Psychiatric Press, 1990

Kluft RP: Clinical presentations of multiple personality disorder. Psychiatr Clin North Am 14:605–629, 1991a

Kluft RP: Multiple personality, in American Psychiatric Press Review of Psychiatry, Vol 10. Edited by Tasman A, Goldfinger SM. Washington, DC, American Psychiatric Press, 1991b, pp 161–188

Kluft RP: Hospital treatment of multiple personality disorder: an overview. Psychiatr Clin North Am 14:695–719, 1991c

Kluft RP: Thoughts on the psychodynamic psychotherapy of the dissociative disorders. The Psychodynamic Letter 1:1–5, 1991d

Koopman C, Classen C, Spiegel DA: Predictors of posttraumatic stress symptoms among survivors of the Oakland/Berkeley, Calif, firestorm. Am J Psychiatry 151: 888–894, 1994

Krystal JH, Bennett A, Bremner J, et al: Toward a cognitive neuroscience of dissociation and altered memory functions in post-traumatic stress disorder, in Neurobiological and Clinical Consequences of Stress: From Normal Adaptation to PTSD. Edited by Friedman M, Charney D, Deutch A. New York, Lippincott-Raven, 1995, pp 239–269

Lanius A, Vermetten E, Loewenstein J, et al: Emotion modulation in PTSD: clinical and neurobiological evidence for a dissociative subtype. Am J Psychiatry 167:640–647, 2010

LeDoux J: The Synaptic Self: How Our Brains Become Who We Are. New York, Viking Penguin, 2002

Levine HB: Clinical issues in the analysis of adults who were sexually abused as children, in Adult Analysis and Childhood Sexual Abuse. Edited by Levine HB. Hillsdale, NJ, Analytic Press, 1990, pp 197–218

Lindy JD: Psychoanalytic psychotherapy of post traumatic stress disorder: the nature of the therapeutic relationship, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. Edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996, pp 525–536

Lindy JD, Green BL, Grace MC, et al: Psychotherapy with survivors of the Beverly Hills Supper Club fire. Am J Psychiatry 37:593–610, 1983

Lisman-Pieczanski N: Countertransference in the analysis of an adult who was sexually abused as a child, in Adult Analysis and Childhood Sexual Abuse. Edited by Levine HB. Hillsdale, NJ, Analytic Press, 1990, pp 137–147

Loewenstein RJ, Ross DR: Multiple personality and psychoanalysis: an introduction. Psychoanalytic Inquiry 12:3–48, 1992

Marmar CR, Weiss DS, Schlenger WE, et al: Peritraumatic dissociation and posttraumatic stress in male Vietnam theater veterans. Am J Psychiatry 151:902–907, 1994

Marmer SS: Multiple personality disorder: a psychoanalytic perspective. Psychiatr Clin North Am 14:677–693, 1991

McLaughlin AA, Keller SM, Feeny NC, et al: Patterns of therapeutic alliance: rupture-repair episodes in prolonged exposure for posttraumatic stress disorder. J Consult Clin Psychol Nov 4, 2013, doi:10.1037/a0034696 [Epub ahead of print]

Mercer KB, Orcutt HK, Quinn JF, et al: Acute and post traumatic stress symptoms in a prospective gene x environment study at a university campus shooting. Arch Gen Psychiatry 69:89–97, 2012

Modell AH: Trauma, memory, and the therapeutic setting, in Understanding Therapeutic Action: Psychodynamic Concepts of Cure (Psychoanalytic Inquiry Series, Vol 15). Edited by Lifson LE. Hillsdale, NJ, Analytic Press, 1996, pp 41–50

Morgan CA, Hazlett G, Wang S, et al: Symptoms of dissociation in humans experiencing acute, uncontrollable stress: a prospective investigation. Am J Psychiatry 158:1239–1247, 2001

Mulder RT, Beautrais AL, Joyce PR, et al: Relationship between dissociation, childhood sexual abuse, childhood physical abuse, and mental illness in a general population sample. Am J Psychiatry 155:806–811, 1998

Novick KK, Novick J: Postoedipal transformations: latency, adolescence, and pathogenesis. J Am Psychoanal Assoc 42:143–169, 1994

Ogden TH: The Primitive Edge of Experience. Northvale, NJ, Jason Aronson, 1989

Perry S, Difede J, Musngi G, et al: Predictors of post traumatic stress disorders after burn injury. Am J Psychiatry 149:931–935, 1992

Putnam FW: Diagnosis and Treatment of Multiple Personality Disorder. New York, Guilford, 1989

Putnam FW: Dissociative phenomena, in American Psychiatric Press Review of Psychiatry, Vol 10. Edited by Tasman A, Goldfinger SM. Washington, DC, American Psychiatric Press, 1991, pp 145–160

Putnam FW: Dissociation in Children and Adolescents: A Developmental Model. New York, Guilford, 1997

Putnam FW, Guroff JJ, Silberman EK, et al: The clinical phenomenology of multiple personality disorder: review of 100 recent cases. J Clin Psychiatry 47:285–293, 1986

Rabin RC: Nearly one in five women in US survey say they have been sexually assaulted. The New York Times, December 15, 2011, p 828

Rauch SL, Shin LM: Functional neuroimaging studies in posttraumatic stress disorder. Ann N Y Acad Sci 821:83–98, 1997

Schnyder U, Moergeli H, Klaghofer R, et al: Incidence and prediction of posttraumatic stress disorder symptoms in severely injured accident victims. Am J Psychiatry 158:594–599, 2001

Schottenbauer MA, Glass CR, Arnkoff DB, et al: Nonresponse and dropout rates in outcome studies on PTSD: review and methodological considerations. Psychiatry 71:134–168, 2008

Siegal DJ: Memory, trauma, and psychotherapy: a cognitive science view. J Psychother Pract Res 4:93–122, 1995

Simeon D, Lowenstein RJ: Dissociative disorders, in Comprehensive Textbook of Psychiatry. Edited by Sadock BJ, Sadock VA, Ruiz P. Philadelphia, PA, Wolters Kluwer/Lippincott Williams and Wilkins, 2009, pp 2009–2226

Spiegel D: Dissociation and trauma, in American Psychiatric Press Review of Psychiatry, Vol 10. Edited by Tasman A, Goldfinger SM. Washington, DC, American Psychiatric Press, 1991, pp 261–275

Spiegel D: Trauma, dissociation, and memory. Ann N Y Acad Sci 821:225–237, 1997

Spiegel D, Li D: Dissociated cognition and disintegrated experience, in Cognitive Science and Unconscious. Edited by Stein DJ. Washington, DC, American Psychiatric Press, 1997, pp 177–187

Spiegel D, Scheflin AW: Dissociated or fabricated? psychiatric aspects of repressed memory in criminal and civil cases. Int J Clin Exp Hypn 42:411–432, 1994

Spiegel D, Lowenstein RJ, Lewis-Fernandez R, et al: Dissociative disorder in DSM-5. Depress Anxiety 28:824–852, 2011

Squire LR: Declarative and nondeclarative memory: multiple brain systems supporting learning and memory. J Cogn Neurosci 4:232–243, 1992

Steinberg M, Rounsaville B, Cicchetti D: Detection of dissociative disorders in psychiatric patients by a screening instrument and a structured diagnostic interview. Am J Psychiatry 148:1050–1054, 1991

Storr CL, Ialongo NS, Anthony JC: Childhood antecedents of exposure to traumatic events and post traumatic stress disorder. Am J Psychiatry 164:119–125, 2007

Target M: Book review essay: the recovered memories controversy. Int J Psychoanal 79:1015–1028, 1998

van der Kolk BA: The compulsion to repeat the trauma: re-enactment, revictimization, and masochism. Psychiatr Clin North Am 12:389–411, 1989

Van Ommeren M, de Jong JTVM, Sharma B, et al: Psychiatric disorders among tortured Bhutanese refugees in Nepal. Arch Gen Psychiatry 58:475–482, 2001

Vythilingam M, Heim C, Newport J, et al: Childhood trauma associated with smaller hippocampal volume in women with major depression. Am J Psychiatry 159:2072–2080, 2002

Waller NG, Ross CA: The prevalence and biometric structure of pathological dissociation in the general population: taxometric and behavior genetic findings. J Abnorm Psychol 106:499–510, 1997

Williams LM: Recall of childhood trauma: a prospective study of women's memories of child sexual abuse. J Consult Clin Psychol 62:1167–1176, 1994

Yehuda R: Sensitization of the hypothalamic-pituitary-adrenal axis in posttraumatic stress disorder. Ann N Y Acad Sci 821:57–75, 1997

Young WC: Psychodynamics and dissociation: all that switches is not split. Dissociation 1:33–38, 1988

Youngner CG, Rothbaum BD, Friedman MJ: Treatment of post-traumatic stress disorder, in Gabbard's Treatment of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

CHAPTER
11

PARAPHILIAS AND SEXUAL DYSFUNCTIONS

Paraphilias

Few psychiatric disorders are fraught with as many moralistic overtones as the paraphilias. To determine that an individual is deviant in the area of sexuality implies the establishment of a clear norm for sexual behavior. Who will establish such norms? Shall psychiatry be the moral guardian of sexual behavior? Can we use terms such as *sexual deviation, perversion,* or even *paraphilia* without sounding pejorative?

The evolution of the definition of perverse activity reveals the extent to which psychiatric nosology mirrors the society from which it emanates. In the context of a culture that viewed normal sexuality in relatively narrow terms, Freud (1905/1953) defined sexual activity as perverse according to several criteria: 1) it focused on nongenital regions of the body; 2) rather than coexisting with the standard practice of genital intercourse with an opposite-sex partner, it superseded and replaced such practice; and 3) it tended to be the exclusive sexual practice of the individual. Freud noted that traces of perversion could be found in virtually anyone whose unconscious was subject to psychoanalytic exploration.

Since Freud's early paper, cultural attitudes about sexuality have undergone dramatic changes. As sexuality became a legitimate area for scientific study, it became apparent that "normal" couples engage in a variety of sexual behaviors. Oral-genital relations, for example, became widely accepted as

healthy sexual behavior. Homosexuality and anal intercourse similarly were removed from the list of perverse activities.

Psychoanalytic writers have repeatedly confirmed Freud's observation that there is a latent perverse core in all of us (Chasseguet-Smirgel 1983; McDougall 1980, 1986; Stoller 1975, 1985). Thus a more accepting attitude about perverse sexuality has accompanied psychoanalytic advances. McDougall (1986) pointed out that perverse fantasies are regularly found in all adult sexual behavior but tend to cause few problems because they are not experienced as compulsive. She suggested using the term neosexuality to reflect the innovative nature of the practice and the individual's intense investment in its pursuit. She stressed that clinicians must be empathic with patients who experience these sexual demands as necessary for emotional survival. In her view, the term perversion should be reserved for instances in which one person imposes personal wishes on a partner who is reluctant to engage in that individual's sexual scenario or seduces a nonresponsible individual, such as a child or mentally handicapped adult (McDougall 1995).

Stoller (1975, 1985) advocated a narrowed definition of perverse activity. Referring to perversion as "the erotic form of hatred" (1975, p. 4), he asserted that cruelty and the wish to humiliate and degrade one's sexual partner as well as oneself are the crucial determinants of whether a behavior is perverse. From this perspective, the individual's intent is a critical variable in defining perversion. As his view evolved, Stoller (1985) added another dimension to this definition. Recognizing that in normal sexual arousal there is a touch of hostility and a desire to humiliate, he concluded that intimacy was a critical differentiating factor. An individual is perverse only when the erotic act is used to avoid a long-term, emotionally intimate relationship with another person. Conversely, sexual behavior is not perverse when it is in the service of establishing a stable intimate relationship.

In the service of being nonjudgmental in its definition of paraphilias, DSM-5 (American Psychiatric Association 2013) makes a distinction between paraphilia and paraphilic disorders. This distinction recognizes that unconventional forms of sexual behavior do not necessarily cause harm or distress. Paraphilic disorders, on the other hand, are diagnosed if they cause personal harm and/or distress to self or others. Hence, in this regard, DSM-5 acknowledges the distinction between the sexual behaviors that cause clinical concern and those that are simply unusual or different in any way. The tradition of psychodynamic psychiatry is to withhold judgment on different choices that people make in their lives regarding romance, partnership, and sexual choices. Clinicians must respect the differences in perspective and subjectivity in all their patients but particularly those who engage in intimate behaviors that are different from their own.

Psychodynamic Understanding

To a large extent, the etiology of paraphilias remains shrouded in mystery. Psychological issues obviously play a crucial role in determining the choice of paraphilia and the underlying meaning of the sexual acts. Psychoanalytic understanding has greatly illuminated the dark recesses of sexual desire. However, we must appropriately and modestly note that psychodynamic models can shed light on the meaning of a paraphilia without necessarily establishing a definitive etiology (Person 1986).

The classical view of perversions is deeply embedded in drive theory. Freud (1905/1953) believed that these disorders illustrate how instinct and object are divorced from one another: "It seems probable that the sexual instinct is in the first instance independent of its object" (p. 148). Moreover, he defined perversions in part by contrasting them with neuroses. In the latter condition, neurotic symptoms represent a transformation of repressed perverse fantasies. In perversions, however, the fantasies become conscious and are directly expressed as ego-syntonic, pleasurable activities. Hence, Freud described neuroses as the negative of perversions: neurotic symptoms were desexualized perverse fantasies. In the classical view, perversions may be fixations or regressions to infantile forms of sexuality persisting into adult life (Fenichel 1945; Sachs 1986). Some remnant of infantile experience is preserved in consciousness and is the carrier of all infantile sexuality through the process of displacement. A perverse act becomes a fixated and ritualized procedure that is the only route to genital orgasm. In the classical formulation (Fenichel 1945), the decisive factor that prevents orgasm through conventional genital intercourse is castration anxiety. Perversions thus serve the function of denying castration. (Because the overwhelming majority of patients with paraphilias are male, the formulations presented here presume male gender.)

Freud (1905/1953) appreciated the multilayered complexity of perversions. He noted, for example, the myriad unconscious determinants of voyeurism and exhibitionism, which are opposite sides of the same coin. In his clinical work, he observed that any "active" perversion was always accompanied by a "passive" counterpart. In this formulation, the sadist would have a masochistic core, whereas the voyeur would have unconscious exhibitionistic desires.

More recent psychoanalytic investigators have concluded that drive theory alone is insufficient to explain the fantasies and behavior seen clinically and that the relational aspects of paraphilia are crucial for a comprehensive understanding (McDougall 1980, 1986; Mitchell 1988). According to Stoller (1975, 1985), the essence of perversion is a conversion of "childhood trauma to adult triumph" (Stoller 1975, p. 4). Patients are driven by their

fantasies of avenging humiliating childhood traumas caused by their parents. Their method of revenge is to dehumanize and humiliate their partner during the sexual act or fantasy. Bergner (2002) has observed that in sexually compulsive individuals, the preferred scenarios typically originate in childhood experiences of degradation. The sexually exciting fantasies of such individuals are designed to recover from the early degradation by leading to personal redemption. Unfortunately, the scenarios become impossible standards against which actual relationships pale by comparison. Hence the wish to transcend the degradation is never fulfilled.

Paraphilic sexual activity may also be a flight from object relatedness (Mitchell 1988). Many persons with paraphilias have incompletely separated and individuated from their intrapsychic representations of their mothers. As a result, they feel that their identity as a separate person is constantly being threatened by fusion or engulfment from internal or external objects. Sexual expression may be the one domain in which they can assert their independence. Whereas Stoller (1975, 1985) viewed paraphilias as expressions of the desire to humiliate, Mitchell (1988) understood them as a defiance of the overbearing influence of the internal mothering figure. One aspect of the relief experienced by paraphilic patients after they have acted on their sexual desires is their feeling of triumph over the controlling mother within.

McDougall (1986) noted other object relational meanings of the neosexualities. She suggested that sexual behavior evolves from a complicated matrix of identifications and counteridentifications with our parents. Each child is involved in an unconscious psychological drama that stems from the parents' unconscious erotic desires and conflicts. Hence, the obligatory nature of any neosexuality is programmed by parental scripts internalized by the child. In McDougall's view, deviant sexual behavior may function partly to protect the introjected objects from the patient's aggression by acting out the unconscious drama "written" by the parents.

Kohut (1971, 1977) offered a self psychological perspective on the function of paraphilias. In his view, paraphilic activity involves a desperate attempt to restore the integrity and cohesiveness of the self in the absence of empathic selfobject responses from others. The sexual activity or fantasy may help the patient feel alive and intact when threatened by abandonment or separation. This behavior in the course of psychotherapy or analysis may thus be a reaction to failures of empathy by the therapist, leading to a temporary disruption of the self–selfobject matrix established between patient and therapist (Miller 1985).

Although not a self psychologist, McDougall (1986) also noted a profound fear of loss of identity or sense of self at the core of much paraphilic activity. Certain sexual practices or sexual objects become like a drug that

the patient uses to "medicate" a sense of inner deadness and a fear of self-disintegration. In these patients, McDougall observed a faulty internalization process that impeded their use of transitional objects in childhood during their efforts to separate from maternal figures.

Goldberg (1995) extended the self psychological view. He believed that sexualization is an attempt to repair a structural defect in the self that is connected to an incapacity to manage and experience painful emotional states. He also linked paraphilia to a vertical split within the personality between the "real me" part and a disavowed sector that is seen to initiate and promulgate sexualized acts. However, Goldberg also stressed that generalizations about psychodynamic themes are unwarranted because a wide variety of dynamics may be involved in any particular sexualized scenario.

Authors like Mitchell, McDougall, Kohut, and Goldberg paved the way to a broader understanding of paraphilias that is more in the realm of representations of self and object than pure sexuality. Ogden (1996) suggested that patients establish a sexualized mode of relatedness as a way of evading an experience of psychological deadness. They enact a drama designed to present a false impression that they are actually alive in their power to excite rather than deadened and empty. Parsons (2000) noted that such behavior stems from an inability to tolerate the "otherness" of a separate person. The patient engages in a perverse scenario as a defense against experiencing another person as complex, real, and different from oneself. Paraphilia involves a mode of relatedness that bypasses a genuine connection with the other person and uses power to seduce, dominate, or exploit the other person without true recognition of self and other in an intimate relationship. Many such patients experience intimacy as dangerous or deadly during childhood and spend their lives avoiding it. Those who pursue infantilism, or adult baby syndrome (Pate and Gabbard 2003), may dress as babies, wear diapers, and act as though they are a child in hopes of coercing others into a quasi-maternal role that utterly disregards the other person's subjectivity.

Traditional clinical wisdom has suggested that perversions are rare in women. This point of view has been changing in recent years as the result of empirical research and clinical observation demonstrating that paraphilic fantasies are actually common in women. In a comprehensive study of female perversions, Louise Kaplan (1991) pointed out that clinicians have failed to identify perversions in women because they involve more subtle dynamics than the more obvious sexuality of men's perversions. Sexual acts stemming from female paraphilias involve unconscious themes of separation, abandonment, and loss. For example, some women who have been sexually abused as children adopt an exaggerated stereotype of female sexiness in an effort to wreak vengeance on men and reassure themselves about their femaleness.

Before considering the dynamics of each individual paraphilia, it should be noted that the reasons for individual preference of one fantasy or act over another remain obscure. Also, different paraphilias often coexist in the same person. Although the traditional view of perversion held that the perverse individual is fixated on one type of sexual scenario, a study of 561 men seeking evaluation and treatment for paraphilia found that fewer than 30% of subjects (excluding transsexuals) had confined their deviant behavior to only one paraphilia (Abel et al. 1988). Some individuals will sequentially shift from one paraphilia to another. In a 40-year outcome report, Lehne and Money (2000) described a 65-year-old man who, in his youth, engaged in paraphilic cross-dressing. Over time he shifted to pedophilia and eventually to prolonged infantilism.

A wide range of psychiatric diagnoses and levels of personality organization may be present in a paraphilic individual. Paraphilias have been observed, for example, in psychotic patients, in those with personality disorders, and in relatively intact or neurotic patients. Polymorphous perverse sexuality is commonly found in patients with borderline personality organization (Kernberg 1975). Paraphilias that involve overt cruelty to others are often present in patients with antisocial personality disorder. Thus, the psychodynamic understanding of any individual patient involved in unconventional sexual activity implies a thorough comprehension of how the activity interacts with the patient's underlying character structure. For example, patients with neurotic organization may use a paraphilic activity to facilitate genital potency, whereas patients near the psychotic border may use the same activity to fend off a sense of dissolution of the self (Person 1986).

Exhibitionism and Voyeurism

By publicly exposing his genitals to strange women or girls, the exhibitionist reassures himself that he is not castrated (Fenichel 1945; Freud 1905/1953). The reaction of shock that his actions produce helps him deal with castration anxiety and gives him a feeling of power over the opposite sex. Stoller (1985) pointed out that exhibitionistic acts typically follow a situation in which the offender felt humiliated, often at the hands of a woman. In turn, the exhibitionist avenges this humiliation by shocking women strangers. Moreover, displaying his genitals enables the man to regain some sense of worth and positive masculine identity. Frequently these men reveal a profound insecurity about their sense of maleness. Stoller (1985) noted that castration anxiety does not completely capture the motivation for the exhibitionistic act. In his view, the threat "is best put in identity terms; for humiliation is about 'existence anxiety,' threat to core gender identity" (p. 20). Exhibitionists often feel that they made no impact on anyone in their family,

and thus they have had to resort to extraordinary measures to be noticed (Mitchell 1988). Each exhibitionistic act may therefore be an attempt to reverse a childhood traumatic situation.

The flip side of exhibitionism—voyeurism—also involves a violation of a strange woman's privacy, an aggressive but secretive triumph over the female sex. Fenichel (1945) linked voyeuristic tendencies to a fixation on the primal scene of childhood, in which the child either witnesses or overhears parental intercourse. This early traumatic experience could arouse the child's castration anxiety and then lead him to reenact the scene again and again as an adult in an attempt to actively master a passively experienced trauma. Fenichel also identified an aggressive component in looking, conceptualizing it as a guilt-avoiding displacement of the wish to be directly destructive to women. Even patients who are not prone to overtly voyeuristic activities may exhibit common derivatives such as curiosity and anxiety about looking. Some patients are even reluctant to glance around their therapist's office for fear that their curiosity will be construed as destructive or that they will see something forbidden. Mitchell (1988) observed that exhibitionism and voyeurism capture an essential quality typical of all paraphilias: "a dialectic between surface and depth, between the visible and the secret, between the available and the withheld" (p. 111).

Sadism and Masochism

Persons who require sadistic fantasies or actions to achieve sexual gratification are often unconsciously attempting to reverse childhood scenarios in which they were the victim of physical or sexual abuse. By inflicting on others what happened to them as children, they gain revenge and a sense of mastery over the childhood trauma at the same time. Stoller (1991) found that a rather large percentage of members of sadomasochistic clubs who practiced body piercing had been hospitalized as children and had continually received injections in order to treat their childhood illnesses. Masochistic patients who require humiliation and even pain to achieve sexual pleasure may also be repeating childhood experiences of abuse. Fenichel (1945) believed that masochistic patients are making a sacrifice—accepting a "lesser evil" in place of castration. They may also be firmly convinced that they deserve punishment for their conflictual sadistic wishes. In some cases, these patients defend against separation anxiety by submitting to abuse. They are frequently convinced that a sadomasochistic relationship is the only available form of object relatedness: an abusive relationship is better than no relationship.

Sadism and masochism are unique in that they are the only classical perversions that are acknowledged to occur regularly in both sexes (Person

1986). Although masochism has been stereotypically linked to women, muted forms of sadistic and masochistic fantasies are regularly found in almost everyone. The practices of male homosexuals and the reports of female prostitutes with heterosexual males even suggest that masochistic sexual activities may be more common in men. Sacher-Masoch, the 19th century Austrian writer from whom the term derives, was, in fact, a poet of male masochism. All sexual arousal may indeed be linked to aggressive wishes (Stoller 1985). Patients who come to psychotherapy or psychoanalysis with sexual inhibitions often reveal highly sadistic fantasies that prevent them from becoming sexually involved with other people.

In relational terms, sadism often develops from a particular internal object relationship in which the withholding and distant object requires a forceful effort to overcome its resistance to the corresponding self representation (Mitchell 1988). Similarly, masochistic surrender may be an enactment of an internal object relationship in which the object will respond to the self only when humiliated.

From a self psychological perspective, masochistic behavior is a frantic effort to restore a sense of aliveness or self-cohesion. Although apparently self-destructive, masochism may be experienced by the patient as self-restorative. Stolorow et al. (1988) reported the treatment of a highly disturbed 19-year-old patient who repeatedly asked the therapist to hit her. In response to the therapist's persistent inquiries about why she would want him to strike her, she wrote: "Physical pain is better than spiritual death" (p. 506). In the absence of physical pain and abuse at the hands of others, this patient felt that she did not exist and was not connected with anyone else. These authors noted that masochistic patients often organize their entire lives to meet their parents' needs. As a result, their own internal affective experience becomes remote and unavailable because it has been sacrificed in the service of their parents.

The ascendance of the Internet has led to active social organizations of individuals and couples who often identify themselves as "BDSM." In addition to sadism and masochism, these initials refer to bondage/discipline and domination/submission forms of coupling. Some may prefer to be tied up and restrained, whereas others actively seek out punishment. Often the endurance of pain is in the service of a mode of relatedness. In some couplings, submissives may simply enjoy giving over authority to dominant partners so that they are told what to do in all areas of their lives. In this regard, pain may not be the major goal. Organizations have formed rules for safe and consensual practices, such as not leaving a partner alone and having clear communication when an activity has gone too far so it can be stopped. Most individuals engaged in this type of consensual coupling do not seek psychiatric treatment. If they do seek out couples therapy, they may completely ig-

nore the sadomasochistic consensual activity and focus on other relational problems. One study involving semistructured interviews with 14 therapists experienced in working with BDSM patients (Lawrence and Love-Crowell 2008) found that BDSM was rarely a central issue in therapy. These therapists suggested that cultural competence is important for the therapist so that a nonjudgmental understanding and attitude is conveyed to the patients. Attempts to encourage the patients to change their practices may disrupt the therapeutic alliance or end the therapy. Patients in these situations clearly fall in the category of paraphilia rather than paraphilic disorder, as stipulated by DSM-5.

Fetishism

To achieve sexual arousal, fetishists require the use of an inanimate object, often an article of women's underwear, or a shoe, or a nongenital body part. Most of these fetishistic activities cause no harm to self or others and would not be considered paraphilic disorders. Freud originally explained fetishism as stemming from castration anxiety. The object chosen as a fetish symbolically represented the "female penis," a displacement that helped the fetishist overcome castration anxiety. Following the premise that male awareness of the female genitals increased a man's fear of losing his own genitals and becoming like a woman, Freud thought that this unconscious symbolization explained the relatively common occurrence of fetishism. He also used this formulation to develop his concept of the splitting of the ego (Freud 1940/1964)—coexisting in the fetishist's mind are two contradictory ideas: denial of castration and affirmation of castration. The fetish represents both.

Although Greenacre (1970, 1979) also viewed castration anxiety as central to the understanding of fetishism, she noted that it has its origins in earlier pregenital disturbances. Chronic traumatic interactions in the first few months of life may thus be instrumental in producing fetishism. Because of severe problems in the mother–infant relationship, the infant is unable to be soothed by the mother or by transitional objects. To experience bodily integrity, the child thus requires a fetish, something "reassuringly hard, unyielding, unchanging in shape, and reliably durable" (Greenacre 1979, p. 102). These early pregenital disturbances are reactivated later when the male child or adult is concerned about genital integrity. In essence, Greenacre saw the fetish as functioning like a transitional object.

Kohut (1977) held a somewhat similar view about fetishism, although couched in self psychological terms. He described a male patient whose childhood was characterized by the traumatic unavailability of his mother. The patient made a fetish of underpants, which served as a substitute for the unavailable selfobject. In contrast to this patient's feelings of helplessness

about his mother, he could maintain total control over this nonhuman version of a selfobject. Thus what appears to be an intense sexual need for a fetishistic object may actually reflect severe anxiety about the loss of one's sense of self (Mitchell 1988).

More recent writing on fetishism has broadened the concept to include fetishism as part of a spectrum of phenomena that control anxiety by bestowing magic and illusion on an outside object (Nersessian 1998). Fetishism has also been expanded beyond inanimate objects and is thought to exist in females as well as males. Rather than attempting to link fetishism to anxiety connected with a specific developmental moment, contemporary views focus more on the ego's need for an outside object to master anxiety. In a prospective longitudinal study, Massie and Szajnberg (1997) described a case of amputee fetishism in which a 30-year-old man recalled the onset of a sexual fetish in his fifth or sixth year of life. The historical information and parent–infant film data in the research record, coupled with the patient's historical recollections, provided a complex and illuminating view of the evolution of a fetish. Several factors were clearly at work, including an unusually intense and sexually exciting relationship with both mother and father, a propensity for strong psychophysiological arousal, difficulties with self-soothing, an overstimulating and highly sensitive alertness on the part of both parents to the child's psychological life, and the early experience of the loss of the father for 10 weeks in the child's third year. This actual trauma appeared to contribute to a vulnerability to separation anxiety. The specific form of the fetish, involving amputee images, could also be related to a caretaker who had her leg in a cast and the boy's anxieties about the cast "coming off." Massie and Szajnberg speculate that fetishism in this case may have been linked to a form of intrapsychic posttraumatic play.

Pedophilia

Of all the paraphilic disorders, pedophilia is the most likely to create feelings of disgust and contempt in treaters. In fulfilling his sexual desires, the pedophile may irreparably damage innocent children. The DSM-5 diagnostic criteria for pedophilic disorder stipulate that the individual must have persistent sexual fantasies or desires involving sex with a prepubescent child (typically under the age of 13). To qualify for pedophilic disorder, one must also be at least 18 years of age and at least 5 years older than the victim. Not all individuals who have sexually abused a child necessarily meet the DSM-5 criteria for pedophilic disorder, nor do all individuals with a sexual interest in children actually go on to commit child sexual abuse (Murphy et al. 2014). Some conceptual framework or psychodynamic formulation can enable clinicians to maintain a degree of empathy and understanding when at-

tempting to treat these patients. According to the classical view (Fenichel 1945; Freud 1905/1953), pedophilia represents a narcissistic object choice—that is, the pedophile sees a child as a mirror image of himself as a child. Pedophiles were also regarded as impotent and weak individuals who sought children as sexual objects because they would offer less resistance or create less anxiety than adult partners, thus enabling pedophiles to avoid castration anxiety.

In clinical practice, many pedophiles are found to have serious personality disorders. A study (Raymond et al. 1999) of incarcerated pedophiles found that 60% had a personality disorder; 20% had narcissistic personality disorder, and 22.5% had antisocial personality disorder. Sexual activity with prepubescent children may shore up the pedophile's fragile self-esteem. Similarly, many pedophiles with this perversion choose professions in which they can interact with children because the idealizing responses of children help them maintain their positive self-regard. In return, the pedophile often idealizes these children; thus, sexual activity with them involves the unconscious fantasy of fusion with an ideal object or restoration of a youthful, idealized self. Anxiety about aging and death may be warded off through sexual activity with children.

When pedophilic activity occurs in conjunction with a narcissistic personality disorder or an outright psychopathic character structure (see Chapter 17), the unconscious determinants of the behavior may be closely linked to the dynamics of sadism. Sexual conquest of the child is the tool of vengeance. Pedophiles were frequently victims of childhood sexual abuse themselves (Fagan et al. 2005), and a sense of triumph and power may accompany their transformation of a passive trauma into an actively perpetrated victimization.

Power and aggression are also prominent concerns of pedophiles whose sexual activity is limited to incestuous relationships with their own children or stepchildren. These men often feel unloved by their wives, and they elicit caretaking responses from their children by portraying themselves as victims (Ganzarain and Buchele 1990). The flip side of their martyred self-presentation, however, is a sense of control and power over their sexual partners. These incestuous fathers harbor extraordinary hostility toward women, and they often think of the penis as a weapon to be used in acts of vengeance against women. Some have even acknowledged that feelings of intense anger produce erections (Ganzarain and Buchele 1990).

Pedophiles are often differentiated according to whether they are fixated or regressed (Groth and Birnbaum 1979; McConaghy 1998). The fixated pedophile is sexually attracted to younger persons from the time of adolescence, whereas the regressed pedophile usually does not show sexual attraction to younger people until adulthood. Fixated pedophiles generally

commit their offenses against boys, whereas their regressed counterparts more often than not sexually exploit girls. Those who offend against girls typically carry out their offenses in the home as part of an incestuous relationship and tend to have very few victims. Fixated pedophiles, who choose boys as the object of sexual desire, tend to have many victims and prey on boys who live outside the home. Because the regressed pedophile may also be attracted to adult women, the prognosis is much better than that for the fixated pedophile, who mainly focuses on boys.

An overall treatment plan for a patient with pedophilia must take into account comorbidity. Child molesters have been shown to have high levels of psychopathology (Ahlmeyer et al. 2003). In addition to extensive comorbidity, pedophilic offenders have been shown to have structural impairments of brain regions critical for sexual development. Volume reduction in the right amygdala and closely related structures may be implicated in the pathogenesis of pedophilia, making the treatment extraordinarily challenging (Schiltz et al. 2007).

Transvestism

In transvestism, the male patient dresses as a woman to create sexual arousal in himself that leads to heterosexual intercourse or masturbation. Because there is no harm or coercion in cases of transvestism, these individuals would not be considered to suffer from a paraphilic disorder and do not necessarily need treatment. The patient may behave in a traditionally masculine manner while dressed as a man but then become effeminate when dressed as a woman. The classic psychoanalytic understanding of cross-dressing involves the notion of the phallic mother. By imagining that his mother possesses a penis, even if it is not clearly visible, the male child overcomes his castration anxiety. The act of cross-dressing may thus be an identification with the phallic mother (Fenichel 1945).

At a more primitive level, the little boy may identify with his mother to avoid anxiety about separation. His awareness of genital differences between him and his mother may activate anxiety that he will lose her because they are separate individuals. Clinical work with transvestites reveals that when they cross-dress, they commonly experience some degree of fusion with an intrapsychic maternal object. This reassures them that they are not in danger of losing the soothing maternal presence within. These men are always heterosexual (Person 1986), and most are otherwise well adjusted. In a study of 188 cross-dressing men (Brown et al. 1996), transvestites were found to be indistinguishable from the average man on tests of sexual functioning, personality, and emotional distress. These individuals rarely seek psychiatric treatment. Although transvestites are ordinarily quite convinced that they

are heterosexual and male, some may appear at clinics at midlife convinced that they have become transsexuals. The individuals in these cases are not thought to be true transsexuals requiring surgical sex reassignment, because comorbidity of transsexualism and transvestism is considered extremely rare (Bower 2001).

Treatment Considerations

Patients with paraphilias are notoriously difficult to treat. Over many years, they have developed a carefully crafted erotic solution to their problems, and they are rarely interested in giving it up (McDougall 1986). Why would someone wish to halt a practice that produces great pleasure? Most paraphilias are ego-syntonic; only exceptional patients who are distressed by their symptoms willingly seek treatment.

The vast majority of paraphilic patients come to treatment under pressure. A marital crisis may bring a transvestite to clinical attention under threat of divorce. In instances of voyeurism, exhibitionism, and particularly pedophilia, legal pressures often mandate treatment as a condition of probation or as an alternative to incarceration. A court date may be pending, so the patient will go through the motions of treatment to "look good" in court and to influence the judge to drop any charges. In most cases of paraphilia, the first order of business is to clarify the legal situation. The clinician may decide to defer a decision on long-term treatment until after the disposition of the case in court. Those patients who continue to seek treatment after all legalities have been resolved may have better prognoses (Reid 1989).

Another major impediment to the treatment of patients with paraphilic disorders is the countertransference responses they evoke. If indeed we all struggle with unconscious perverse wishes, as Freud and many others since his time have repeatedly suggested, then it is reasonable to assume that we may react to the patient as we would to our own perverse impulses. We are filled with disgust, anxiety, and contempt. Our natural impulse is to respond punitively—to moralize, to chide, to lecture, and to do what we can to "stamp out" the perversity. We recoil in horror at the prospect of anyone allowing full rein to such impulses when we ourselves carefully control them. However, we may also take voyeuristic pleasure in hearing the detailed accounts of our patients' sexual activities (Fagan et al. 2005). Another countertransference tendency is to collude with the patient's avoidance of the paraphilia by talking about other aspects of his life. Clinicians can avoid their own feelings of disgust and contempt by avoiding the whole area of sexual pathology. With some patients—pedophiles, in particular—certain therapists may feel that they simply cannot be effective because of their intense countertransference hatred. In these instances, it is best to refer the patient elsewhere.

One final reason for difficulty in treating persons with perversions is the associated psychopathology. One study of 113 men convicted of sexual offenses (Dunsieth et al. 2004) found that 85% had a substance use disorder and 56% met criteria for antisocial personality disorder. Paraphilic fantasy and behavior are difficult enough to alter, but when the patient's condition is complicated by serious chemical dependency or antisocial character pathology, the prognosis becomes even more guarded.

Whether treatment of paraphilias, especially those involving pedophilia and other criminal offenses, is truly effective remains highly controversial (Hall 1995; Marshall and Pithers 1994; McConaghy 1998; Prentky et al. 1997; Rice et al. 1991). Although some studies are encouraging, the validity of the outcome measures used at follow-up is highly problematic. Using recidivism, as measured by arrest records, casts a narrow net. Because round-the-clock observation of pedophiles, for example, is impossible, researchers cannot be certain whether they continue to act on their impulses to molest children.

The vast majority of research on treatment effectiveness with paraphilias has been conducted with sexual offenders (Fagan et al. 2005). Most sex offenses, however, are not the expression of a paraphilia. Moreover, most paraphilias primarily create concern within the affected individual rather than leading directly to criminal sex offenses. Hence the skewed population involved in the empirical research on paraphilias leads to great difficulty in determining which treatments are effective for which persons with paraphilias. We are not yet at a point where we can say that a specific psychotherapeutic treatment is uniquely effective for any one paraphilia or for all types of paraphilia (Fagan et al. 2005). As Murphy et al. (2014) assert,

> If there is one common theme that emerges from a review of treatments over the last hundred years, it is that a combination of treatment paradigms is more effective than a single approach or treatment algorithm applied dogmatically. What works well for one person may not work at all for another.

Most treatment programs involve integrated models that are individually tailored to the patient. Most sex offenders receive some combination of relapse prevention and cognitive-behavioral therapy, but experts say that the efficacy is extremely difficult to determine given the problems with compliance with treatment and with the collection of accurate follow-up data. There is a substantial psychoanalytic and psychotherapeutic literature on the treatment of some forms of paraphilia (Fogel and Myers 1991; Goldberg 1995; Kaplan 1991; McDougall 1980, 1986, 1995; Person 1986; Rosen 1964, 1979; Stoller 1985). The treatment goals generally include assisting patients in overcoming their denial and helping them develop empathy for their victims; identifying and treating deviant sexual arousal; identifying social defi-

cits and inadequate coping skills; challenging cognitive distortions; and developing a comprehensive relapse prevention plan that includes avoidance of situations in which the patient is likely to be tempted.

In contemporary treatment of many paraphilias, especially in situations in which a sex crime has been committed, psychotherapy is combined with a medication that lowers testosterone. The two main types of testosterone-reducing medications are antiandrogens and gonadotropin-releasing hormone partial agonists (Fedoroff 2010). Although these agents may be somewhat effective in lowering sex drive, the drugs have problematic side effects and are controversial. It is hard to ensure that sex offenders will comply with the medication, and the drugs do not address the underlying psychological issues. Even when the drugs are effective in reducing testosterone levels, a substantial number of offenders continue to engage in deviant sexual fantasies and behavior. The agents most commonly used are cyproterone acetate, Depo-Provera, Depo-Lupron, or triptorelin (Berlin et al. 1995; Rosler and Witztum 1998). Some of these agents have serious side effects, however, including decreased sperm production, hyperinsulinemic response to glucose load, weight gain, breast nodules, thromboembolic phenomena, and adrenal suppression. There is also the possibility of an increased risk of liver cell carcinoma (Briken et al. 2001). As a result, some have tried using more benign agents, such as selective serotonin reuptake inhibitors and luteinizing hormone–releasing hormone agonists.

Psychotherapeutic Treatments

Individual expressive-supportive psychotherapy with an expressive emphasis may be the preferred method of treatment in some cases of paraphilia, but a therapist's expectations must nevertheless be modest. Although many patients will make considerable gains in object relatedness and ego functioning, their underlying paraphilic tendencies may be modified to a lesser degree. In general, those patients with higher-level character organizations have a better outcome than those with borderline levels of organization (Person 1986).

Similarly, those patients who are psychologically minded, who possess some degree of motivation, who have some distress about their symptoms, and who are curious about the origins of their symptoms are likely to do better than those who lack such qualities.

Certain problems typically arise when paraphilic persons are treated with dynamic psychotherapy. These patients rarely wish to focus on the paraphilia itself and often actively assert that it is no longer a problem for them. Although psychotherapists must treat disorders associated with the paraphilia, they must also vigorously confront such denial from the beginning. One therapeutic task is to integrate the sexual behavior with the cen-

tral sector of the patient's personality functioning so that it can be addressed along with the rest of the patient's life. The vertical split in the patient's personality may give rise to parallel but distinct transference phenomena. Each transference will produce corresponding countertransferences, often involving a form of collusion with the paraphilia. Goldberg (1995) suggested that the therapist must both recognize the behavior as essential for the patient's emotional survival and regard it as something to be understood and diminished. He noted that in this regard the vertical split in the transference is met with a corresponding split response in the therapist.

Another frequently encountered dilemma in psychotherapy centers around the avoidance of a punitive stance vis-à-vis the patient's paraphilic activity. Most states have reporting laws that require a therapist to break confidentiality if pedophilic activity is uncovered during psychiatric treatment. Even apart from the legal and ethical considerations, paraphilic behavior is likely to evoke highly disapproving responses in therapists. Sensitive patients often detect the therapist's struggle to refrain from being punitive. Clever patients may exploit this countertransference struggle by accusing their therapist of being harsh and cruel because of the focus on the sexual symptom. Patients may also avoid discussing the symptom by instead professing their feelings of shame, embarrassment, and humiliation.

If the patient can overcome his initial resistance to forming a therapeutic alliance in the service of understanding the symptom, then both patient and therapist can begin to search for unconscious meanings of the symptom and its function within the patient's personality. Most paraphilias operate in an object relations context outside the patient's awareness. Many patients with paraphilias experience their fantasies and behavior as essentially nonpsychological, and they are unaware of any connections between their symptoms and feeling states—or between their symptoms and life events—that may increase their need for the symptoms. Much of the therapist's effort must therefore go into explaining these connections.

> Mr. S, a 22-year-old college student, was hospitalized after an arrest for exposing himself to female students on the campus. He would sit in his car in the parking lot of the women's dormitory with his genitals exposed. As female students walked by, some would look in the car and react with shock, which substantially excited him. During his brief hospitalization, Mr. S agreed to start psychotherapy, but he was basically a reluctant participant. He told his therapist that his embarrassment and depression upon being arrested and hospitalized would prevent him from ever resorting to exhibitionism again. He preferred to use the therapy to talk about other problems, such as his difficulties with self-esteem and with applying himself to his studies at college.
>
> The therapist confronted this denial and suggested that the problem of exhibitionism had not disappeared simply because Mr. S had been hospitalized. Following discharge from the hospital, Mr. S continued to struggle with exhi-

bitionistic impulses, occasionally giving in to them. Each time he reported such impulses in therapy, his therapist would invite reflection on possible precipitants of the impulses or actions. Mr. S seemed genuinely perplexed as he searched his memory for antecedent events or feelings. The wish to expose himself was so integral to his identity that he did not think of it as developing out of any affective or relational context.

On one occasion after Mr. S exposed himself, his therapist pointed out that the episode of exposure had occurred immediately after a young woman in one of his classes had turned him down when he asked her out for a date. Mr. S acknowledged that he had felt rebuffed and humiliated and that he could understand the possibility that exposing himself was an expression of his anger and revenge when women failed to respond to him. He began to notice a pattern of increasing exhibitionistic impulses whenever he experienced a rebuff or rejection from any woman he pursued romantically. With help from the therapist, Mr. S was able to link his anger at women with his deep resentment of his mother for returning to full-time work outside the home when Mr. S was 2 years old.

When the therapy began to address these sensitive aspects of Mr. S's relationships with women, he abruptly terminated treatment. Several years later, however, he wrote to his therapist, indicating that he had found the key to overcoming his urge to expose himself. Although his exhibitionistic tendency still haunted him once in a while, he had managed to control it by teaching himself "to learn to love women." He had discovered, through a positive relationship with a young woman, that some women actually did care about him. He thanked the therapist for helping him see that he had been distorting the feelings women had toward him. When he realized that women did not automatically resent him because he was a man, he felt less fearful around them and less compelled to take revenge against them through exhibitionistic activity.

Marital therapy may be critical to the successful treatment of paraphilias. A marital crisis may precipitate the patient's seeking of treatment in the first place. Marital therapy can often help delineate how the paraphilic activity reflects sexual and emotional difficulties in the marital dyad. It may also alleviate the wife's unwarranted feelings of guilt and responsibility for the behavior and can instead facilitate a sense that she is part of its solution rather than part of its cause (Kentsmith and Eaton 1978). An exploration of marital discord may also reveal that the paraphilia is a container or "scapegoat" that deflects the focus from other more problematic areas in the marriage (Reid 1989). Clinicians must therefore be innovative in using the patient's spouse as an adjunctive therapist in refractory cases of paraphilia. For example, one man who was unresponsive to a number of treatments for his exhibitionism was able to control the symptom only when his wife agreed to drive him everywhere he went. In cases of transvestism, the main focus of treatment may be helping the patient's wife accept that the cross-dressing behavior is unlikely to change and assisting her in becoming more tolerant of her husband's need to wear women's clothing.

In cases of pedophilia that occur in the context of incest, family therapy is ordinarily an integral part of the overall treatment plan. Mothers typically collude in these incestuous arrangements by turning a blind eye to the abundant evidence of father–daughter (or occasionally father–son) sexual relations. These mothers frequently grew up as parentified children who never received the nurturance they needed in childhood because they were too busy taking care of their own parents and siblings (Gelinas 1986). They tend to marry highly needy, dependent men as a continuation of their propensity for caretaking. Because of chronic feelings of neglect, the mother in such a family is likely to be highly ambivalent about raising children, and when children arrive, she may feel overwhelmed and neglect her husband as a result. As mother and father become more estranged, the father turns to one of the children—usually the eldest daughter—for nurturance, leading to a second generation of the parentified-child pattern. This child is likely to feel responsible for filling the mother's shoes, and when part of that responsibility entails sexually satisfying her own father, she may subordinate her own needs and rights to his. She exists to satisfy the needs of others. Indeed, family therapy in cases of incest often reveals that the victim protects the offender and maintains loyalty toward him. Effective family therapy requires careful attention to these dynamics. The victim's loyalty to the offender must be acknowledged and respected. It is also helpful to focus on the father's wish for relatedness and emotional connectedness rather than on sexuality or perversion (Gelinas 1986). Incest victims often report that the only warmth they ever received in their family of origin was from the father. The depletion of the mother's emotional resources must also be addressed empathically, and the therapist must bolster her ego capacities. The therapist who approaches the family by identifying and seeking to punish villains will be met with massive resistance—the family members will "circle the wagons" to exclude an outside attacker who does not appreciate the homeostatic balance within the family system.

Dynamic group psychotherapy is another modality that has been used effectively in patients with perversions. Voyeurs and exhibitionists may respond well to group modalities. In one study (Rosen 1964), 21 of 24 patients were recovered or improved at follow-up 6–36 months later. Legally enforced group therapy with sex offenders, such as pedophiles, has also obtained satisfactory results, even on an outpatient basis (Ganzarain and Buchele 1990; Rappeport 1974). These groups provide a mixture of support and confrontation from other offenders who are intimately familiar with the patient's problem, just as homogeneous groups of drug addicts and alcoholics bring group pressure to bear to change destructive behavior. Ganzarain and Buchele (1990) found that excluding severely disturbed pedophiles—those with organic brain syndrome, psychosis, substance abuse, pure sociopathy, and ex-

clusive perversions—can facilitate identification of a subgroup of pedophiles who will respond well to expressive group psychotherapy. Although patients in their group of offenders frequently denied responsibility and externalized blame, many had unconscious guilt feelings and a profound sense of shame and humiliation about having been discovered. Typically, however, these feelings were fended off by considerable resistance to psychotherapeutic exploration. Because the treatment was legally mandated, many of the offenders viewed the group therapists as agents of the court and therefore assumed the posture of "doing time." Those patients with lower degrees of sociopathy and greater unconscious guilt feelings ultimately were able to use the group therapy process to understand that their hatred of women grew out of their wish to be loved. This understanding led to greater control of sexual impulses and general improvement in their capacity for object relations.

Hospital Treatment

Those paraphilic patients most likely to be hospitalized are pedophiles and, to a lesser extent, exhibitionists who are simply unable to control their behavior on an outpatient basis. Many of the same countertransference problems described for psychotherapeutic treatments also arise in hospital treatment. The patient's denial of his paraphilia may lead staff members to collude with him by focusing on other problems. One exhibitionist would regularly sit in the lounge of the hospital unit with an erection visible underneath his sweatpants. However, no one on the nursing staff reported noticing this behavior until the doctor pointed out that one manifestation of countertransference with this patient was a fear of looking. This same patient would also often stand nude in his room until a female nurse made rounds; he would then act surprised and indignant when she saw him. When the patient's doctor brought up this behavior in a group meeting on the unit, the patient tried to marshal support from his fellow patients by accusing the doctor of being insensitive and cruel by embarrassing him in front of his peers.

In general, patients with paraphilias will object to discussing their problems in group meetings or community meetings on an inpatient unit. However, when staff members comply with requests to avoid sexual issues in treatment meetings, they are colluding with the patient's tendency to go through an entire hospitalization without dealing with the perversity that necessitated the hospitalization. Many pedophiles are extraordinarily smooth individuals who will charm other patients into avoiding confrontations.

> Mr. T, a 41-year-old teacher, had been extensively involved in pedophilic sexual activities for many years. When the hospital staff insisted that he mention his child-molesting in the community meeting on the unit, Mr. T complied, but in such a manner that he received no feedback from any of the other pa-

tients. He began by saying that he loved children and was concerned about the future of America. He talked at great length about his love for his own two daughters and his concern about how his hospitalization might affect them. He admitted to sexual behavior with children but made it sound benign. He explained that he had never forced any sexual activity on any child and he claimed that, in fact, all his victims had enjoyed their physical contact with him. He spoke of it in terms of "hugging" and "stroking," and he maintained that it had always occurred in the context of a loving friendship. By the time he finished his narrative account, the other patients were quite sympathetic. The psychiatrist in charge of the meeting asked if anyone was shocked or repulsed by Mr. T's behavior. Everyone denied any such reaction.

Pedophiles on a hospital unit may virtually paralyze patient groups from giving them the effective feedback given other patients. In addition, those with striking antisocial personality features may simply lie so that their paraphilic behavior is never dealt with during their hospitalization. One such patient maintained for all 6 weeks of his hospitalization that he had been falsely accused. On the day of his discharge, he acknowledged to his doctor with a chuckle that he actually had molested a child but had not wanted to admit it. As this patient packed his bags to leave the unit, his doctor was left feeling frustrated and impotent to do anything to improve the patient's condition.

Other pedophiles may convince staff members that they are complying with treatment by going through the motions required by it. They appear to use the insights gained in psychotherapy about the origin of their impulses and desires but secretly have no interest in changing themselves. They "play the game" of treatment because it is far preferable to prison, where pedophiles are often subject to gang rape or murder. One pedophile who was a model patient during his hospitalization reported that his pedophilic impulses were thoroughly under control at discharge. He even said that he was no longer turned on by children. Upon transfer to a halfway house after discharge, he continued to report that he was no longer troubled by his pedophilic desires. This illusion was shattered when the police issued a warrant for his arrest stemming from two instances of child molestation. This pattern of deceiving staff members while going through the motions of treatment is all too common among this patient population. Some pedophiles may therefore do far better in correctional facilities with specialized programs for sex offenders that involve group confrontational approaches.

Sexual Dysfunctions

In contrast to many of the sections in DSM-5, the section on sexual dysfunction introduced a number of major changes in the classification. Although

sexual dysfunctions had previously been geared to the linear sexual response cycle involving desire-excitement-orgasm-resolution, subsequent research showed that sexual response is actually heterogeneous and not at all linear.

As a result, DSM-5 changed the nomenclature and made sexual dysfunctions more gender specific. For women there is no separate sexual desire disorder or arousal disorder in DSM-5. Rather, they are combined into female sexual interest/arousal disorder. However, there is little research on this new diagnostic entity, so treaters must improvise.

Another major change is that all of the sexual dysfunctions now require a minimum duration of approximately 6 months as well as more precise severity criteria. The only exception to this duration requirement is those sexual problems that are substance induced. Dyspareunia and vaginismus are no longer separate diagnoses. They are combined into genito-pelvic pain/penetration disorder. Finally, sexual aversion disorder was eliminated. The new classification system focuses on problems of decreased sexual functioning (see Table 11–1).

Although the popular media frequently refer to "sex addiction," there are not enough data available to support inclusion of a diagnostic category, so the proposed *hypersexual disorder* was not included (Balon and Clayton 2014). Moreover, there is no standard that defines normal sexual behavior, and there is a potential to be moralizing and judgmental, that is, dictating how much sexual behavior is acceptable or nonpathological.

Behavioral techniques in the treatment of sexual dysfunction dominated the field for many years, largely based on the fundamental work of Masters and Johnson (1970). After initial excitement, studies appeared that reported somewhat sobering results (Kilmann et al. 1986; O'Connor and Stern 1972). Sex therapists recognized that the motivation of couples, the state of their marital relationship, and the specific sexual symptoms had a great deal of impact on whether the behavioral techniques were effective (Lansky and Davenport 1975). Problems intrinsic to the desire phase, for example, were often resistant to sex therapy. Helen Singer Kaplan (1974, 1979, 1986) developed a sophisticated model for combining behavioral techniques with dynamic approaches.

More recently, the development of medications for erectile dysfunction, such as Viagra (sildenafil citrate), has dramatically changed the practice of sex therapy. A survey of the major journals in the field (Winton 2001) found that the focus of the field of sexual dysfunctions has shifted to male erectile dysfunction. Many of these problems are readily treatable with medications, and there has been an increased interest in treating women with hypoactive sexual desire and orgasmic dysfunction with sustained-release bupropion (Modell et al. 2000; Segraves et al. 2001). Some experts (Rowland 2007) have expressed concern that the medicalization of the treatment of sexual dysfunc-

TABLE 11–1. Sexual dysfunctions included in DSM-5

Delayed ejaculation
Erectile disorder
Female orgasmic disorder
Female sexual interest/arousal disorder
Genito-pelvic pain/penetration disorder
Male hypoactive sexual desire disorder
Premature (early) ejaculation
Substance/medication-induced sexual dysfunction
Other specified sexual dysfunction
Unspecific sexual dysfunction

tion may make sexological care obsolete. Other observers have noted that human sexuality is gradually being abandoned by psychiatry to the point where a sexual history is often not taken (Balon 2007). However, the problems that arise from a reductive approach and the side effects encountered by various medications suggest that the biopsychosocial perspective on sexual dysfunction must not be abandoned. In fact, some experts believe that psychotherapy is now more relevant than ever (Althof 2007). A report of a survey of sexuality and health among adults in the United States (Lindau et al. 2007) attracted great attention when it appeared in the *New England Journal of Medicine*. It noted that about half of both men and women reported at least one bothersome sexual problem, and, perhaps even more disconcerting, it found that these problems are infrequently discussed with physicians. There is a growing consensus in the field that these problems require a biopsychosocial perspective for understanding and treatment because of the multifactorial nature of most sexual dysfunctions (Balon and Clayton 2014).

Clinicians have long known that when a sexual problem is the chief complaint in an initial interview, it is often only the tip of the iceberg. The advent of erectile dysfunction medications has led to the emergence of a variety of marital problems in couples who had achieved more-or-less stable equilibrium with only occasional sexual contact. Many couples found themselves having to renegotiate their marital relationship to help clarify the nature of the intimacy problems that had been masked by the erectile dysfunction. Some men began to have extramarital affairs because they were no longer anxious about their capacity to achieve or maintain an erection. With celebrity endorsements of agents for erectile dysfunction appearing on television and in magazines, it became a topic that could be discussed openly. Greater research efforts have thus been possible. Men still have approximately a 3-year lag between the onset of erectile problems and seeking

treatment because of shame and embarrassment over the symptom (Moore et al. 2003). Regardless of whether physical causes are related to the symptom, many men feel a significant blow to their self-esteem when they cannot perform sexually. Hence individual and marital/conjoint therapy may still be needed, even with the availability of specific medications. Moreover, a significant percentage of men and women do not respond to the drugs currently being used for sexual dysfunction.

Psychodynamic Understanding

Brief sex therapy and/or pharmacotherapy may be the most cost-effective treatment for individuals and couples who have difficulty attaining orgasm but who have no serious associated psychopathology. Disorders associated with desire and arousal tend to be more refractory to brief sex therapy because they are anchored in more deep-seated psychopathological factors (Kaplan 1986; Reid 1989). This discussion focuses on problems in these areas.

The psychodynamic understanding of the male or female patient who has no desire for sex, or of the male patient who has desire but is unable to achieve an erection, begins with a careful understanding of the symptom's situational context. If the patient is involved in an intimate relationship, the clinician must determine whether the problem of desire or arousal is specific to the partner or is generalized to all potential sexual partners. Sexual difficulties that are specific to the couple—as opposed to those representing primarily intrapsychic difficulties that would occur with any partner—must be understood in the context of the interpersonal dynamics of the dyad. Clinicians must remember, however, that desire problems, like all other psychological symptoms, are multiply determined.

A 1999 national probability sample (Laumann et al. 1999) revealed that problematic relationships, in both the present and the past, are highly linked to sexual dysfunctions. In fact, all categories of sexual dysfunction in women in this study showed strong associations with unhappiness and low feelings of emotional and physical satisfaction. Arousal disorder in women was significantly linked to sexual victimization through adult–child contact or forced sexual contact. In a more recent study (Reissing et al. 2003), vaginismus was also linked to higher rates of sexual abuse and less positive sexual self-schema. Male victims of adult–child contact were found to be three times as likely to experience erectile dysfunction as those who had not been victimized. Male victims of childhood sexual abuse were also twice as likely to experience premature ejaculation and low sexual desire compared with control subjects who were free from childhood trauma. The investigators emphasized that long-lasting and profound effects on sexual functioning seem to result from traumatic sexual acts in both sexes.

Levine (1988) delineated three discrete elements of sexual desire that must function in synchrony for adequate desire and arousal: drive, wish, and motive. Drive is rooted in biology and may be affected by physical factors, such as hormonal levels, medical illnesses, and medications. The wish element is more intimately connected to conscious cognitive or ideational factors. For example, in the presence of a normal drive component, an individual may wish to not have sex because of religious prohibitions or because of a fear of contracting HIV. The third element, motive, is intimately related to unconscious object relational needs and is the component most likely to be the focus of therapeutic intervention.

The clinician must assess all three elements and must attempt to understand why these are not integrated into a functional whole. Numerous factors may interfere with an individual's motivation. One partner in the marriage may be having an extramarital affair and may simply have no interest in the spouse; one spouse may feel so chronically resentful and angry toward the other that sexual relations are out of the question. Problems in the couple's nonsexual relationship probably account for most instances of inhibited sexual desire. A sexual partner's transference distortions can also play a key role in disturbing motivation. In many couples who enter sex or marital therapy, the spouses are unconsciously relating to one another as if to the opposite-sex parent. When this occurs, sexual relations may unconsciously be experienced as incestuous, so the partners manage the anxiety associated with this taboo by avoiding sex altogether. Simpson (1985) reported a case of sex therapy in which the wife was highly resistant to carrying out the prescribed exercises. When this resistance was explored dynamically, the wife was able to acknowledge to the therapist that part of her wanted her husband to fail in sex therapy. She revealed her fear that her husband would become a "womanizer" like her father if he regained adequate sexual functioning. This transference distortion of her husband threatened to undermine the success of the sex therapy. Even single individuals in therapy or analysis may experience transference-like attachments to a potential sex partner that result in disorders of motivation.

> Mr. U was a 25-year-old, single professional man who entered psychoanalysis because of various problems in his capacity to work and love. The drive component of Mr. U's sexual desire was entirely adequate—he masturbated several times a day to relieve intense sexual tension. The wish component of desire was also intact. He aspired to sexual relations with an appropriate female and fantasized about doing so. However, the motivational element seemed lacking, as evidenced by his characteristic behavior pattern each time he became attracted to a woman. As he talked about the woman in analysis, he would become tearfully convinced that he would ultimately lose the current object of his longings. His anticipation of the loss aroused such intense

feelings of grief and so overwhelmed him that he would decide not to pursue a relationship at all but instead to simply retreat into solitary masturbation.

Each time Mr. U experienced these feelings of anticipatory loss, his analyst would try to elicit any associations to previous events or life experiences that might bring up analogous feelings. After a considerable period of analytic work, the patient finally began to make sense of his feelings. When the patient was 5 years old, his father had been away at war for a year. During this time, Mr. U had been "the man of the house," occupying a special position with his mother in the absence of his chief rival for her affections. At times he had even slept in bed with her. When Mr. U's father returned, however, the patient suffered a devastating loss of this special, intimate relationship with his mother.

The patient's memory of this period in his life helped him understand his motives not to pursue sexual relations. As soon as he became infatuated with a woman, he began to form a maternal transference attachment. Reexperiencing her (at an unconscious level) as his mother, he became convinced that she, too, would "dump" him for another man, just as his mother had turned him aside for his father. Mr. U feared confronting that grief again, which led him to avoid sexual relations. This insight also put Mr. U in touch with considerable castration anxiety. He realized that he was deeply worried that his penis might be injured during sex, a concern that he eventually associated with his fear of retaliation for having taken his father's place in his mother's bed.

Our capacity for sexual arousal and desire is clearly connected intimately with our internal object relations. Scharff (1988) developed an object relations model of inhibited sexual desire based on Fairbairn's (1952) theories of development (see Chapter 2). Fairbairn postulated two "bad object" systems, the libidinal ego and object, in which the ego longs for a tantalizing object, and the antilibidinal ego and object, in which the ego feels hatred and anger toward an attacking, abandoning, or negligent object. The rejecting or antilibidinal object attempts to eliminate the exciting or libidinal object. In Scharff's model, then, this antilibidinal system interferes with sexual excitement, which derives from the libidinal system.

These metapsychological abstractions can be more easily understood by examining the development of a typical relationship. Individuals are attracted to one another as a result of activation of the libidinal or need-exciting object system. Via mutual projective identification, each regards the other as the exciting object. To maintain the idealized "in love" state, each must repress the antilibidinal or rejecting object. However, as the luster and freshness of the relationship wear off, the repressed object relations unit begins to surface, particularly when needs are inevitably frustrated. At this point, the rejecting object of the antilibidinal system is projected into the partner, and sexual excitement is contaminated by the perception of the partner as persecuting or abandoning.

In Scharff's model, clinicians must evaluate disturbances of desire according to three different areas of internal and external object relations: 1) the external realities of the couple's current marital relationship; 2) the internal object world of each individual and how it affects the capacity for sexual intimacy; and 3) the current family constellation (including children, elderly parents, and other factors) and how it affects sexual desire. Scharff has noted that sexual desire is greatly affected by the developmental stage of the marriage itself.

Primitively disturbed patients, especially those with schizophrenia and severe borderline features, may find the prospect of genital fusion overwhelming to their fragile ego. Motivational factors in these patients that lead to inhibited sexual desire are related to the primitive anxiety states described in Chapter 9, including disintegration anxiety, persecutory anxiety, and a fear of fusing with one's partner. Abstaining from sexual relations may thus appear to safeguard the integrity of the self. Specific psychodynamic themes are often attached to the experience of orgasm that may be highly disconcerting to patients who are organized at a borderline or psychotic level (Abraham 2002). These must be taken into account when formulating a comprehensive understanding and treatment plan for patients with sexual dysfunction.

Treatment Considerations

The clinician who assesses functional sexual disorders must decide whether to prescribe brief behavioral sex therapy, cognitive therapy, couples therapy, psychoanalysis or expressive-supportive psychotherapy, pharmacotherapy, or any combination of these. Often combinations of treatments are used for maximal benefit. The impact of changes in a couple's sexual performance often has far-reaching effects that require psychotherapeutic intervention. Erectile dysfunction medications like sildenafil have received attention in terms of their potential to disrupt marital equilibrium, but women patients who have been prescribed bupropion also may be overcome with intense sexual desire that feels almost uncontrollable at times (Bartlik et al. 1999), and the impact on a couple may require psychotherapeutic work as well. Balon and Clayton (2014) suggested that when a male patient reports a history of lifelong erectile dysfunction, dynamic psychotherapy is probably an important component of the overall treatment approach. Because of advertising, many patients expect a "miracle drug" when they are prescribed agents such as sildenafil, only to be disappointed that problems involving intimacy, expectations, and disappointment persist.

Indications for the various modalities may not always be clear during the initial evaluation. Brief behavioral sex therapy is likely to be successful if a couple is highly motivated, if neither partner has serious psychopathology, if each partner is reasonably satisfied with the relationship, and if the dysfunc-

tion is based on performance anxiety and related to the orgasm phase. Couples who have inhibited sexual desire and are generally disillusioned with the relationship may require marital therapy for a time to address basic problems in their relationship. If the couple decides to stay together after marital therapy, then sex therapy techniques can be more appropriately recommended.

Couples who seem appropriate candidates for brief sex therapy techniques but who undermine the process by not practicing the exercises may require a hybrid treatment that Helen Singer Kaplan (1979) labeled psychosexual therapy. In this treatment, the therapist prescribes behavioral exercises and then addresses with dynamic psychotherapy any resistances to practicing the exercises. Kaplan found this combination of techniques to be critical to successful treatment with certain patients. The dynamic portion of the treatment allows exploration of themes such as the patient's intense guilt feelings about sexual pleasure. Parental transferences to the partner can also be uncovered and explored. In addition, many patients have unconscious conflicts about being successful in any endeavor—including sexual performance—that may have to be examined. Kaplan (1986) also found that some patients unconsciously act out the role of "loser" or "failure" that they have been assigned in their family of origin.

Patients with severe character pathology or deeply ingrained neurotic conflicts about sexuality should be treated in psychoanalysis or expressive-supportive psychotherapy (Kaplan 1986; Levine 1988; Reid 1989; Scharff 1988). Sometimes these problems surface only during an extended evaluation with sex therapy (Scharff 1988). Certain patients may remain unconvinced of the need for long-term intensive individual psychotherapy until they have tried brief methods and found them ineffective. Extended sex therapy also allows the therapist to gain a greater grasp of the internal object relations of each member of the couple. As described in the section on object relations family and marital therapy in Chapter 5, the therapist "contains" the various projective identifications from both spouses. Therapists who are open to this process can diagnose problematic patterns of object relatedness in the couple through "firsthand experience." When there is deep-seated neurotic conflict about sexuality or when there is severe character pathology, however, sex therapy will often exacerbate these problems (Lansky and Davenport 1975). The prescribed sensate focus exercises will force the couple to confront issues that are habitually avoided because of the way their relationship has been organized. Particularly in cases in which there is a history of sexual trauma, the prescription of sex therapy may be experienced as a form of trauma itself and have far-reaching antitherapeutic effects on the couple.

Mrs. V was a 46-year-old homemaker who entered sex therapy with her husband because of her total lack of interest in sexual relations. After several

unproductive sessions, the sex therapist referred Mrs. V for individual expressive-supportive psychotherapy. She felt relieved when she first saw her individual psychotherapist because she realized that she would not be "forced into sexual relations" with her husband.

She described her marital relationship as involving a caretaking role for herself that produced no gratitude from her husband. He had retired 4 years earlier and now spent his days lying around the house watching television. She was not happy with their relationship, but she seemed to have little interest in changing it. She repeatedly berated herself, saying that she did not deserve a better life than what she had. When this pattern of self-denigration and resignation was pointed out to her by the therapist, Mrs. V confided that every time she had felt good in her life, she had been "zapped." She then recounted numerous examples, including the death of one of her children, to illustrate how she had always been punished for any positive feelings she had had about events in her life.

Although Mrs. V talked about a wide range of topics in her psychotherapy, she steadfastly refused to mention anything about her sexuality or the sexual problems that brought her to treatment in the first place. Her therapist began to feel as though he were coercing her into dealing with her sexual problems. When he gently asked her about them, she responded as though to a rapist, feeling violated and withdrawing into silence. The therapist used his countertransference feelings to diagnose an internal object relation that had been externalized in the psychotherapy. He said to Mrs. V, "You seem to react as though I am traumatizing you with my questions about sexuality. Is this repeating any sexually related trauma from your past?" Mrs. V broke down and tearfully acknowledged a history of early sexual trauma at the hands of an uncle. She also opened up further about her first marriage, explaining that she had had a number of extramarital affairs that led to two illegal abortions. She had always been a "daddy's girl," and she wondered if she had been looking for her father in all those affairs. This insight was coupled with an awareness that she had stopped having affairs when her father died about 18 years earlier. Her father had been involved in some of her marital problems that had resulted from her promiscuity, and he had seemed highly distressed by her unfaithfulness to her husband. She even speculated that her promiscuous behavior in her first marriage might have caused her father's death. With interpretations from the therapist, Mrs. V began to understand that her self-sacrifice and selfless devotion to caring for her husband was a form of psychological reparation for the damage she believed she had inflicted on her father. She also began to understand that she denied herself sexual pleasure to punish herself for her promiscuity and the two abortions.

The case of Mrs. V illustrates how deeply ingrained sexual problems may be ego-syntonic because they fulfill certain psychological needs. Many patients with sexual dysfunctions are actually convinced that they should not experience sexual pleasure, so they are therefore invested in maintaining their symptomatology. The treatment of sexual dysfunctions is a highly value-laden area of psychiatry. Clinicians must temper their countertransference need to cure with a respect for the patient's right to choose a particular

pattern of sexual adjustment. Helen Singer Kaplan (1986) noted that some women who fail to reach orgasm nevertheless report satisfying sexual relations; such women usually do not seek treatment for sexual dysfunction. In addition, many voluntary celibates in religious orders lead happy and productive lives. Finally, clinicians must keep in mind that, for some patients, a sexual symptom is nothing more than an admission ticket to psychotherapy. Once inside the door, these patients become more interested in other areas of their life and the sexual symptoms lose significance.

References

Abel GG, Becker JD, Cunningham-Rathner J, et al: Multiple paraphilic diagnoses among sex offenders. Bull Am Acad Psychiatry Law 16:153–168, 1988

Abraham G: The psychodynamics of orgasm. Int J Psychoanal 83:325–338, 2002

Ahlmeyer S, Kleinsasser D, Stoner J, et al: Psychopathology of incarcerated sex offenders. J Pers Disord 17:306–318, 2003

Althof SE: It was the best of times; it was the worst of times. J Sex Marital Ther 33:399–403, 2007

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Balon R: Is medicalization and dichotomization of sexology the answer? A commentary. J Sex Marital Ther 33:405–409, 2007

Balon R, Clayton AH: Sexual dysfunctions, in Gabbard's Treatment of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Bartlik B, Kaplan P, Kaminetsky J, et al: Medications with the potential to enhance sexual responsivity in women. Psychiatric Annals 29:46–52, 1999

Bergner RM: Sexual compulsion as an attempted recovery from degradation: theory and therapy. J Sex Marital Ther 28:373–387, 2002

Berlin FS, Malin HM, Thomas K: Non-pedophilic and non-transvestic paraphilias. Treatments of Psychiatric Disorders, 2nd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1995, pp 1941–1958

Bower H: The gender identity disorder in the DSM-IV classification: a critical evaluation. Aust N Z J Psychiatry 35:1–8, 2001

Briken P, Mika E, Berner W: Treatment of paraphilia with luteinizing-hormone releasing hormone agonists. J Sex Marital Ther 27:45–55, 2001

Brown GR, Wise TN, Costa PT, et al: Personality characteristics and sexual functioning of 188 cross-dressing men. J Nerv Ment Dis 184:265–273, 1996

Chasseguet-Smirgel J: Perversion and the universal law. International Review of Psychoanalysis 10:293–301, 1983

Dunsieth NW, Nelson EB, Brusman-Lovins LA, et al: Psychiatric and legal features of 113 men convicted of sexual offenses. J Clin Psychiatry 65:293–300, 2004

Fagan P, Lehne G, Strand J, et al: Paraphilias, in Oxford Textbook of Psychotherapy. Edited by Gabbard G, Beck J, Holmes J. Oxford, UK, Oxford University Press, 2005

Fairbairn WRD: Psychoanalytic Studies of the Personality. London, Routledge & Kegan Paul, 1952

Fedoroff JP: Paraphilic worlds, in The Handbook of Clinical Sexuality for Mental Health Professionals, 2nd Edition. Edited by Levine SB, Risen CB, Althof SE. New York, Routledge, 2010, pp 401–424

Fenichel O: The Psychoanalytic Theory of Neurosis. New York, WW Norton, 1945

Fogel GI, Myers WA (eds): Perversions and Near-Perversions in Clinical Practice: New Psychoanalytic Perspectives. New Haven, CT, Yale University Press, 1991

Freud S: Three essays on the theory of sexuality (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 123–245

Freud S: Splitting of the ego in the process of defence (1940), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 23. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 271–278

Ganzarain RC, Buchele BJ: Incest perpetrators in group therapy: a psychodynamic perspective. Bull Menninger Clin 54:295–310, 1990

Gelinas DJ: Unexpected resources in treating incest families, in Family Resources: The Hidden Partner in Family Therapy. Edited by Karpel MA. New York, Guilford, 1986, pp 327–358

Goldberg A: The Problem of Perversion: The View of Self Psychology. New Haven, CT, Yale University Press, 1995

Greenacre P: The transitional object and the fetish: with special reference to the role of illusion. Int J Psychoanal 51:447–456, 1970

Greenacre P: Fetishism, in Sexual Deviation, 2nd Edition. Edited by Rosen I. Oxford, UK, Oxford University Press, 1979, pp 79–108

Groth AN, Birnbaum HJ: Men Who Rape: The Psychology of the Offender. New York, Plenum, 1979

Hall GCN: Sexual offender recidivism revisited: a meta-analysis of recent treatment studies. J Consult Clin Psychol 63:802–809, 1995

Kaplan HS: The New Sex Therapy: Active Treatment of Sexual Dysfunctions. New York, Brunner/Mazel, 1974

Kaplan HS: Disorders of Sexual Desire and Other New Concepts and Techniques in Sex Therapy. New York, Simon & Schuster, 1979

Kaplan HS: The psychosexual dysfunctions, in Psychiatry, Revised Edition, Vol 1: The Personality Disorders and Neuroses. Edited by Cavenar JO Jr, Cooper AM, Frances AJ, et al. Philadelphia, PA, JB Lippincott, 1986, pp 467–479

Kaplan LJ: Female Perversions: The Temptations of Emma Bovary. New York, Doubleday, 1991

Kentsmith DK, Eaton MT: Treating Sexual Problems in Medical Practice. New York, Arco, 1978

Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Kilmann PR, Boland JP, Norton SP, et al: Perspectives of sex therapy outcome: a survey of AASECT providers. J Sex Marital Ther 12:116–138, 1986

Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971

Kohut H: The Restoration of the Self. New York, International Universities Press, 1977

Lansky MR, Davenport AE: Difficulties of brief conjoint treatment of sexual dysfunction. Am J Psychiatry 132:177–179, 1975

Laumann EO, Paik A, Rosen RC: Sexual dysfunction in the United States: prevalence and predictors. JAMA 281:537–544, 1999

Lawrence AA, Love-Crowell J: Psychotherapists' experience with clients who engage in consensual sadomasochism: a qualitative study. J Sex Marital Ther 34:63–81, 2008

Lehne G, Money J: The first case of paraphilia treated with Depo-Provera: 40-year outcome. J Sex Educ Ther 25:213–220, 2000

Levine SB: Intrapsychic and individual aspects of sexual desire, in Sexual Desire Disorders. Edited by Leiblum SR, Rosen R. New York, Guilford, 1988, pp 21–44

Lindau ST, Schumm LP, Laumann EO, et al: A study of sexuality and health among older adults in the United States. N Engl J Med 357:762–774, 2007

Marshall WL, Pithers WD: A reconsideration of treatment outcome with sex offenders. Crim Justice Behav 21:10–27, 1994

Massie H, Szajnberg N: The ontogeny of a sexual fetish from birth to age 30 and memory processes: a research case report from a prospective longitudinal study. Int J Psychoanal 78:755–771, 1997

Masters WH, Johnson V: Human Sexual Inadequacy. Boston, MA, Little, Brown, 1970

McConaghy N: Paedophilia: a review of the evidence. Aust N Z J Psychiatry 32:252–265, 1998

McDougall J: Plea for a Measure of Abnormality. New York, International Universities Press, 1980

McDougall J: Identifications, neoneeds and neosexualities. Int J Psychoanal 67:19–31, 1986

McDougall J: The Many Faces of Eros: A Psychoanalytic Exploration of Human Sexuality. New York, WW Norton, 1995

Miller JP: How Kohut actually worked. Progress in Self Psychology 1:13–30, 1985

Mitchell SA: Relational Concepts in Psychoanalysis: An Integration. Cambridge, MA, Harvard University Press, 1988

Modell JG, May RS, Katholi CR: Effect of bupropion SR on orgasmic dysfunction in non-depressed subjects: a pilot study. J Sex Marital Ther 26:231–240, 2000

Moore TM, Strauss JL, Herman S, et al: Erectile dysfunction in early, middle, and late adulthood: symptom patterns and psychosocial correlates. J Sex Marital Ther 29:381–399, 2003

Murphy L, Bradford JB, Fedoroff JP: Treatment of the paraphilias and paraphilic disorders, in Gabbard's Treatment of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Nersessian E: A cat as fetish: a contribution to the theory of fetishism. Int J Psychoanal 79:713–725, 1998

O'Connor JF, Stern LO: Results of treatment in functional sexual disorders. N Y State J Med 72:1927–1934, 1972

Ogden TH: The perverse subject of analysis. J Am Psychoanal Assoc 34:1121–1146, 1996

Parsons M: Sexuality and perversions 100 years on: discovering what Freud discovered. Int J Psychoanal 81:37–51, 2000

Pate JE, Gabbard GO: Adult baby syndrome. Am J Psychiatry 160:1932–1936, 2003

Person ES: Paraphilias and gender identity disorders, in Psychiatry, Revised Edition, Vol 1: The Personality Disorders and Neuroses. Edited by Cavenar JO Jr, Cooper AM, Frances AJ, et al. Philadelphia, PA, JB Lippincott, 1986, pp 447–465

Prentky RA, Knight RA, Lee AFS: Risk factors associated with recidivism among extrafamilial child molesters. J Consult Clin Psychol 65:141–149, 1997

Rappeport JR: Enforced treatment: is it treatment? Bull Am Acad Psychiatry Law 2: 148–158, 1974

Raymond NC, Coleman E, Ohlerking F, et al: Psychiatric comorbidity in pedophilic sex offenders. Am J Psychiatry 156:786–788, 1999

Reid WH: The Treatment of Psychiatric Disorders: Revised for the DSM-III-R. New York, Brunner/Mazel, 1989

Reissing ED, Binik YM, Khalife S, et al: Etiological correlates of vaginismus: sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. J Sex Marital Ther 29:47–59, 2003

Rice ME, Quinsey VL, Harris GT: Sexual recidivism among child molesters released from a maximum security psychiatric institution. J Consult Clin Psychol 59:381–386, 1991

Rosen I (ed): Pathology and Treatment of Sexual Deviation: A Methodological Approach. London, Oxford University Press, 1964

Rosen I (ed): Sexual Deviation, 2nd Edition. London, Oxford University Press, 1979

Rosler A, Witztum E: Treatment of men with paraphilia with a long-acting analogue of gonadotropin-releasing hormone. N Engl J Med 338:416–422, 1998

Rowland DL: Will medical solutions to sexual problems make sexological care and science obsolete? J Sex Marital Ther 33:385–397, 2007

Sachs H: On the genesis of perversions (translated by Goldberg RB). Psychoanal Q 55:477–488, 1986

Scharff DE: An object relations approach to inhibited sexual desire, in Sexual Desire Disorders. Edited by Leiblum SR, Rosen R. New York, Guilford, 1988, pp 45–74

Schiltz K, Witzel J, Northoff G, et al: Brain pathology in pedophilic offenders: evidence of volume reduction in the right amygdala and related diencephalic structures. Arch Gen Psychiatry 64:737–746, 2007

Segraves RT, Croft H, Kavoussi R, et al: Bupropion sustained release for the treatment of hypoactive sexual desire disorder (HSDD) in non-depressed women. J Sex Marital Ther 27:303–316, 2001

Simpson WS: Psychoanalysis and sex therapy: a case report. Bull Menninger Clin 49: 565–582, 1985

Stoller RJ: Perversion: The Erotic Form of Hatred. New York, Pantheon, 1975
Stoller RJ: Observing the Erotic Imagination. New Haven, CT, Yale University Press, 1985
Stoller RJ: Pain and Passion: A Psychoanalyst Explores the World of S and M. New York, Plenum, 1991
Stolorow RD, Atwood GE, Brandchaft B: Masochism and its treatment. Bull Menninger Clin 52:504–509, 1988
Winton MA: Gender, sexual dysfunctions, and the Journal of Sex and Marital Therapy. J Sex Marital Ther 27:333–337, 2001

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CHAPTER

12

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS AND EATING DISORDERS

In this chapter I consider two diagnostic categories that involve discrete self-destructive symptoms. *Substance-related disorders* are defined by the ingestion of chemicals that may lead to addiction, life-threatening physical problems, and a host of emotional problems. *Eating disorders* are defined by overeating, voluntary purging, and starvation. Both groups of disorders present a complex problem for psychodynamic clinicians: What is the role of dynamic approaches in disorders that require symptom control as a major thrust of the therapeutic effort? In some quarters, psychodynamic understanding is considered irrelevant to the management of addiction and eating disorders. However, a considerable body of clinical and research literature suggests otherwise.

Substance-Related Disorders

In this chapter I will make a distinction between alcoholism and drug abuse by treating them as separate entities. However, all forms of problematic substance use have much in common, and DSM-5 (American Psychiatric Association 2013) has eliminated the former categories of dependence and abuse in order to subsume all forms of substance abuse and dependence under the heading of *substance use disorder.* Most of the symptoms formerly listed un-

der abuse and dependence in DSM-IV are retained in this broadened category. However, the symptom of *drug craving* has been added to the criteria, and the criterion of *repeated drug-related legal problems* has been removed because of its low prevalence and poor fit with other criteria (Hasin et al. 2013). This merging of substance abuse and substance dependence resulted from the findings that common assumptions about the relationship between abuse and dependence were shown to be incorrect in a number of studies.

Psychodynamic psychiatrists have long been frustrated in their efforts to treat patients with alcoholism and drug abuse, and many abandon or avoid such efforts. However, the use of substances is so extensive that no psychiatrist can practice without dealing with them in one way or another. A common experience is for a substance use problem to emerge in the psychotherapy of the patient who is ostensibly in treatment for other reasons. For many years psychiatrists have been frustrated because often they feel that psychodynamic exploration of unconscious motivations have little impact on the drinking behavior itself. Relapse is common, and psychodynamic clinicians realize that their approach is viewed with skepticism by other mental health professionals.

Two other models—the moral model and the disease model—receive much greater support (Cooper 1987). The moral model views alcoholic individuals as bearing complete responsibility for their alcoholism. From this point of view, alcoholic persons are hedonistic individuals interested only in their own pursuit of pleasure, with no regard for the feelings of others. This model has its roots in the fundamentalist religious belief that alcoholism is a sign of moral turpitude. Failings of willpower are closely linked to notions of sin, and punishment through the legal system is often regarded as the appropriate way to deal with alcoholic individuals. Eliminating drinking behavior is a matter of overcoming weak willpower to "pull oneself up by the bootstraps."

The success of Alcoholics Anonymous (AA) and other 12-step programs has led to the increasing popularity of the disease model of substance abuse. In contrast to the moral model, this paradigm relieves the chemically dependent person of responsibility for his or her illness. Just as a diabetic person is not held responsible for diabetes, the alcoholic individual is not held responsible for alcoholism. Chemically dependent persons are viewed as having an inherent predisposition to addiction to exogenous substances; psychological factors are irrelevant. Although this model originated as a backlash to moralizing reactions to—and inhumane treatment of—alcoholic persons, it has recently gained support from genetic studies of substance-related disorders. Even when raised apart from their alcoholic parents, these children have an increased risk of developing alcoholism as adults (Goodwin 1979; Schuckit 1985). Twin studies in both male and female twin pairs (Kendler et al. 1992; Prescott and Kendler 1999) suggest that genetic factors play a major role in

the development of alcoholism, with similar influence for alcohol abuse and alcohol dependence. Increasingly sophisticated research on genetic and environmental risks suggests that there are disorder-specific genetic risks for substance-use disorders in addition to environmental influences (Kendler et al. 2003; Rhee et al. 2003).

Further support for the disease model has come from Vaillant's (1983) prospective study of male alcoholic patients throughout the course of their adult lives. He found that the eventual development of alcoholism could not be predicted from adverse childhood experiences or even from psychological profiles of these subjects as young adults. The only reliable predictor of adult alcoholism was antisocial behavior. Vaillant concluded that depression, anxiety, and other psychological characteristics often associated with alcoholic persons were consequences, rather than causes, of the disorder.

The moral model is more widely applied to drug abusers than to alcoholic persons, however, largely because of the extensive overlap between crime and drug abuse. Much of the controversy over the appropriate response to the national drug problem involves whether addicted persons are more effectively handled through legalistically oriented punitive approaches or medically oriented therapeutic approaches. The disease model and its associated self-help groups have been less successful with drug abusers, as Vaillant (1988) himself pointed out, because of apparent fundamental differences between alcoholic persons and polydrug abusers that require differential approaches. In view of these essential differences, the following section examines the psychodynamic understanding of alcoholic persons and drug abusers in turn.

Psychodynamic Approaches to Alcoholism

The AA approach to the problem of alcoholism has been highly effective in the treatment of many individuals. Although the AA organization itself promotes the disease model, its methods address psychological needs and facilitate lasting structural personality changes (Mack 1981). Abstinence is achieved in an interpersonal context in which alcoholic individuals can experience a caring and concerned community of fellow sufferers. These caring figures can be internalized in the same manner that a psychotherapist is internalized, and they can assist the alcoholic individual with affect management, impulse control, and other ego functions, also as a psychotherapist would. Hence, the psychodynamic model can facilitate an understanding of some of the changes rendered by the AA approach (Mack 1981).

For many alcoholic persons, the psychological changes encouraged by AA and the abstinence associated with commitment to its ideals and regular attendance at the meetings are sufficient treatment. The psychodynamically

sensitive clinician, understanding the value of this approach, must have the good judgment to leave well enough alone. Research has demonstrated that participation in 12-step meetings and the frequency of attendance at them are both positively associated with outcome and that they enhance outcomes when they are combined with psychotherapy (Woody 2014). Clinical experience has repeatedly demonstrated, however, that AA is not suitable for all patients with alcoholism. It apparently works best for those who can accept the idea that they have no control over their drinking and thus need to surrender to a "higher power" and for those who are essentially free of other psychiatric disorders. Frances et al. (2004) emphasized that some patients with social phobia, general avoidance, a distaste toward spirituality, and strong negative reactions to groups in general may opt for individual psychodynamic psychotherapy as an alternative.

Most alcoholism experts would agree that alcoholism is a heterogeneous disorder with a multifactorial etiology (Donovan 1986). What works for one patient may not work for another, and all the treatments are surrounded with controversy. A review of treatment studies (McCrady and Langenbucher 1996) suggested that specific treatments appear to have differential effectiveness with different patient groups. No one type of therapy is consistently better than any other type of therapy. In a nationwide project sponsored by the National Institute on Alcohol Abuse and Alcoholism (Project MATCH Research Group 1997), three types of therapy were compared: cognitive-behavioral therapy, 12-step facilitation to prepare subjects for a commitment to AA, and motivational enhancement therapy aimed at improving readiness and willingness to change drinking habits. Overall, all three treatments had reasonably good results, and none was more successful than any other. Clearly, no treatment is definitive, and clinicians must consider each patient individually, making a careful psychiatric evaluation before developing an individually tailored treatment plan.

Unfortunately, the disease model has promulgated the "de-psychologizing" of alcoholism. The conclusions drawn by Vaillant (1983) are in conflict with those based on other longitudinal studies that suggest that personality factors may be important to an understanding of vulnerability to alcoholism (Sutker and Allain 1988). Moreover, Vaillant's conclusions are only as valid as his instruments of measurement. Dodes (1988) observed that Vaillant's methods are not capable of identifying a critical feature in alcoholic patients—namely, their disturbance in self-esteem as revealed by an inability to care for themselves.

Perhaps the major difficulty with the treatment approach suggested by Vaillant and other strict adherents to the disease model is that it ignores the heterogeneity of the disorder. Alcoholism is not a monolithic entity. In fact, one might more accurately refer to the "alcoholisms" (Donovan 1986). Nu-

merous studies attest that there is no single "alcoholic personality" that predisposes to alcoholism (Donovan 1986; Mulder 2002; Nathan 1988; Sutker and Allain 1988). Although numerous studies link antisocial behavior and hyperactivity to later alcoholism, no personality measures have been found that are specific to vulnerability to later alcohol dependence (Mulder 2002). However, in cases of childhood maltreatment, alcohol use is seven times more common than the controls and occurs 2 years earlier than controls (Kaufman et al. 2007). Alcoholism and substance abuse can also occur at a much higher rate in youths during the second year after the loss of a parent, especially if that parent committed suicide (Brent et al. 2009). Hence, when working with an individual patient, one must be sensitive to traumatic events, psychological issues, personality variables, and family systems issues. A narrow interpretation of the disease model might lead clinicians to ignore how these factors contribute to relapse in the course of the illness.

Although no specific personality traits are predictive of alcoholism, psychoanalytic observers have repeatedly noted structural defects, such as ego weakness and difficulty in maintaining self-esteem (Donovan 1986). Both Kohut (1971) and Balint (1979) noted that alcohol serves the function of replacing missing psychological structures and thereby restores some sense of self-regard and inner harmony. Unfortunately, these effects last only as long as the intoxication. Khantzian (1982) also observed that alcoholic patients have problems with self-esteem, the modulation of affect, and the capacity for self-care. A review of 12 studies of alcoholic patients in whom a specific attempt was made to diagnose personality disorder found that the prevalence of comorbid Axis II conditions varied from 14% to 78% (Gorton and Akhtar 1994). The National Epidemiologic Survey on Alcohol and Related Conditions conducted face-to-face surveys of 43,093 individuals who were aged 18 years and older (Grant et al. 2004). Among those with current alcohol use disorder, 28.6% had at least one personality disorder, whereas 47.7% of those with a current drug use disorder had at least one personality disorder. The association between alcohol or drug use disorders and personality disorders was overwhelmingly positive and significant. Both alcohol and drug use disorders were most strongly linked to antisocial, histrionic, and dependent personality disorders.

These studies are cited not to convince readers that all alcoholic persons have coexisting psychiatric disorders or preexisting intrapsychic deficits, but rather to highlight the obvious fact that addiction to alcohol occurs in a person. An individual may develop alcoholism as the final common pathway of a complex interaction between structural deficits, genetic predisposition, familial influences, cultural contributions, and other assorted environmental variables. A thorough psychodynamic evaluation of the patient will consider the alcoholism and all its contributing factors in the context of the total

person. Whether depression, for example, is a cause or a consequence of alcoholism or a completely separate disease state is of more interest to researchers than to clinicians. When alcoholic individuals sober up and look back at the wreckage caused by their alcoholic existence, they are commonly faced with a good deal of depression. This depression stems from the painful recognition that they have hurt others (frequently those most important to them). They must also mourn the things (e.g., relationships, possessions) that they have lost or destroyed as the result of their addictive behavior. While antidepressant medication may alleviate the depression, psychotherapy can assist in the process of working through these painful issues. Also, assessment and treatment of suicide risk must be part of the overall planning in the treatment of alcoholic patients. Twenty-five percent of all suicides occur in alcoholic individuals, and an alcoholic person's likelihood of suicide is between 60 and 120 times higher than that of a person who is not psychiatrically ill (Murphy and Wetzel 1990). When depression and alcoholism are found together, they appear to have a synergistic or additive effect that results in a disproportionately high level of acute suicidality (Cornelius et al. 1995; Pages et al. 1997).

Another implication of the observation that alcoholism occurs in an individual is that each person will prefer and accept different treatment options. Dodes (1988) noted: "Some patients are able to use only psychotherapy, others can use only AA, and there are those who will best be treated with a combination of the two. Accurate prescription of treatment requires individual clinical judgment" (pp. 283–284). Although Vaillant (1981) declared psychotherapy to be wasteful in the treatment of alcoholism, some patients are able to maintain sobriety with psychotherapy alone (Dodes 1984; Khantzian 1985a). An unfortunate "straw man" stereotype often applied to the dynamic psychotherapy of alcoholic patients is that the therapist uncovers unconscious motivations for drinking while ignoring the patient's actual drinking behavior. The fact that psychotherapy can be misused by some patients and by some therapists does not mean, however, that it should be written off as a treatment (Dodes 1988).

Patients involved in AA are often in psychotherapy as well. In one study, more than 90% of the abstinent alcoholic patients in AA who sought psychotherapy found it helpful (Brown 1985). Most studies have failed to show that one kind of psychotherapy is superior to any other for the treatment of alcoholism or drug abuse (Woody 2014). Psychotherapy and AA often work synergistically. Dodes (1988) observed that alcoholic patients may develop, in self psychological terms, an idealizing or mirror transference to the AA organization. They view it as a caring, idealized figure in their life that sustains and supports them. This transference may be split off from the psychotherapeutic transference, and the psychotherapist is wise to delay analyzing it.

Eventually, the selfobject functions of AA can be internalized enough to improve self-care and heighten self-esteem. After some degree of internalization, psychotherapists can shift the therapy from a supportive to a more expressive emphasis.

Most therapists who work with alcoholic patients argue that abstinence is necessary for psychotherapy to be effective (Frances et al. 2004). However, therapists also recognize that relapse is likely to occur, and most therapists will attempt to work with the motivated patient to understand the stresses that produce relapse and how to avoid future high-risk situations. But when patients continue to drink heavily without motivation or interest in exploring the reasons for drinking, they may need to be referred for residential treatment. The aim of psychodynamic therapy is to shift the need for substances back into a need for people, which includes a therapist (Frances et al. 2004).

Group psychotherapy is also commonly used in both inpatient and outpatient treatment of alcoholism. In a randomized controlled trial of psychodynamic group therapy and cognitive-behavioral therapy for alcohol-dependent patients (Sandahl et al. 1998), patients in both treatment groups improved with 15 weekly 90-minute group sessions. Most of the patients in the psychodynamic group therapy were able to maintain a more positive drinking pattern during the 15-month follow-up period, in contrast to the patients in cognitive-behavioral treatment, who appeared to relapse over time.

Other therapists (e.g., Khantzian 1986) have cautioned against a confrontational approach. Because of the difficulty that many alcoholic patients have in regulating affects such as anxiety, depression, and anger, confrontation in a group setting can be counterproductive or even harmful. Cooper (1987) shared Khantzian's view that confrontation should be used judiciously. He believed that the therapist should empathize with the alcoholic individual's defensive need to avoid painful affect. Cooper advocated inpatient groups that focus on the here and now but are less confrontational. He reported a 55% abstinence rate with patients in such groups compared with 16% for patients in an inpatient group program without group psychotherapy. Those patients who remained in group therapy for at least 25 hours also demonstrated greater compliance with other aspects of the program.

Psychodynamic Approaches to Drug Abuse

Although the disease model is popular in many drug rehabilitation programs, psychodynamic approaches are more widely accepted and valued in the treatment of drug abusers than in the treatment of alcoholic persons. Vaillant (1988), for example, noted that polydrug abusers, in contrast to al-

coholic individuals, are more likely to have had unstable childhoods, more likely to use drugs as "self-medication" for psychiatric symptoms, and more likely to benefit from psychotherapeutic efforts to address their underlying symptomatology and character pathology.

A considerable body of research literature supports the association of personality disorder and depression with the development of drug addiction (Blatt et al. 1984a; Compton et al. 2007; Gorton and Akhtar 1994; Grant et al. 2004; Hasin et al. 2011; Kandel et al. 1978; Paton et al. 1977; Treece 1984; Treece and Khantzian 1986; Walsh et al. 2007). Indeed, part of the association between Cluster B personality disorders and substance use disorders can be explained by common underlying personality traits such as self-harm and impulsivity (Casillas and Clark 2002).

Compared with alcoholic persons, drug abusers are much more likely to have significant coexisting psychiatric disorders. In a large epidemiological study involving interviews with 20,291 persons (Regier et al. 1990), drug abusers had a 53% rate of comorbidity, compared with only 37% for alcoholic individuals. Studies of narcotic-addicted individuals have found other psychiatric diagnoses in as many as 80%–93% (Khantzian and Treece 1985; Rounsaville et al. 1982). The comorbidity rate is also high among cocaine abusers. As many as 73% of those seeking treatment meet lifetime criteria for another psychiatric disorder, with anxiety disorders, antisocial personality disorder, and attention deficit disorder ordinarily preceding the onset of the cocaine abuse, and affective disorders and alcohol abuse usually following the onset of the cocaine abuse (Rounsaville et al. 1991). This high level of comorbidity creates a variety of problems in any treatment setting for addicted individuals, and most experts agree that the presence of other psychiatric disorders in the context of a major drug abuse problem constitutes an indication for psychotherapy as part of the treatment program (Mercer and Woody 2005).

The early psychoanalytic interpretation of all substance abuse as a regression to the oral stage of psychosexual development has been replaced by an understanding of most drug abuse as *defensive* and *adaptive* rather than regressive (Khantzian 1985b, 1986, 1997; Wurmser 1974). Drug use may actually reverse regressive states by reinforcing defective ego defenses against powerful affects such as rage, shame, and depression. The early psychoanalytic formulations often depicted persons with drug addictions as pleasure-seeking hedonists bent on self-destruction. Psychoanalytic investigators understand addictive behavior more as a reflection of a deficit in self-care than as a self-destructive impulse (Khantzian 1997). This impairment in self-care results from early developmental disturbances that lead to an inadequate internalization of parental figures, leaving the addicted person without the capacity for self-protection. Hence, most chronic drug-addicted

individuals exhibit a fundamental impairment in judgment about the dangers of drug abuse.

Equally important in the pathogenesis of drug addiction is the impaired regulatory function in affect and impulse control and in maintenance of self-esteem (Treece and Khantzian 1986). These deficits create corresponding problems in object relations. Heavy polydrug use has been related directly to the addicted person's incapacity for tolerating and regulating interpersonal closeness (Nicholson and Treece 1981; Treece 1984). Contributing to these relationship problems are the narcissistic vulnerability inherent in interpersonal risks and the inability to modulate the affects associated with closeness. Dodes (1990) noted that addicted individuals ward off a sense of powerlessness or helplessness by controlling and regulating their affective states. The ingestion of a drug can thus be viewed as a desperate attempt to compensate for deficits in ego functioning, low self-esteem, and related interpersonal problems.

Many drug-addicted patients knowingly perpetuate their pain and suffering by continuing to use drugs. Khantzian (1997) regarded this pain-perpetuating aspect of substance abuse as a manifestation of a repetition compulsion of early trauma. In some cases, the repetitive infliction of pain on oneself represents an attempt to work out traumatic states that cannot be remembered. These states exist as presymbolic and unconscious configurations. A longitudinal study of an epidemiological sample of young adults (Reed et al. 2007) found that association of posttraumatic stress disorder with subsequent drug use disorders remains substantial after statistical adjustment for early life experiences. The investigators noted that trauma may be a causal determinant of drug use disorders, possibly representing efforts to self-medicate trauma-associated memories, hyperarousal symptoms, or nightmares. Thus, the motive for the drug use can be viewed as control of suffering rather than relief from it.

The notion that drug-addicted individuals are medicating themselves leads directly to another observation of contemporary psychodynamic investigators—namely, that specific substances are chosen for specific psychological and pharmacological effects according to each abuser's needs. The most painful affect is likely to be what determines the choice of drug. Khantzian (1997) noted that cocaine appears to relieve distress associated with depression, hyperactivity, and hypomania, whereas narcotics apparently tone down feelings of rage.

An in-depth study of narcotic-addicted individuals led Blatt et al. (1984a, 1984b) to conclude that heroin addiction is multiply determined by 1) the need to contain aggression, 2) a yearning for gratification of longings for a symbiotic relationship with a maternal figure, and 3) a desire to alleviate depressive affects. Although the research data indicate that a small subgroup of

individuals with narcotic addictions also have antisocial personality disorder (Rounsaville et al. 1982), Blatt and colleagues identified a larger group of severely neurotic opiate-addicted persons that may represent the majority. These individuals struggle with feelings of worthlessness, guilt, self-criticism, and shame. Their depression appears to intensify when they attempt to become close to others, so they withdraw into isolated "bliss" brought on by heroin or other narcotics, which has both regressive and defensive dimensions. The depressive core of the opiate-addicted individual was further substantiated by a comparison study (Blatt et al. 1984a, 1984b) that found persons with opiate addictions to be significantly more depressed than polydrug abusers. This study also identified self-criticism as a main component of their depression.

The finding of Blatt and his colleagues of a high correlation between superego-ridden, self-critical, depression-prone personality features and opiate addiction has received support from Wurmser's (1974, 1987a, 1987b) psychoanalytic work with addicted patients. Wurmser argued that those addicted individuals amenable to psychoanalytic therapy do not have underdeveloped superegos, as do antisocial persons with addictions, but rather have an excessively harsh conscience. The intoxicating substance is sought as an escape from a tormenting superego. Many drug abusers employ the defense of splitting to disavow a drug-abusing self representation that alternates with a non-drug-abusing self representation. These individuals often feel as though someone else has taken over for a brief period. Wurmser identified success as a prominent trigger for an episode of drug abuse. Positive feelings associated with successful achievement seem to produce an altered state of consciousness characterized by feelings of guilt and shame. Impulsive drug use is seen as the solution to these painful affects. Recurring crises of this kind are characterized by an overbearing conscience that becomes so intolerable that temporary defiance seems the only means of relief.

Recent psychoanalytic investigators have sought to connect an understanding of drug addiction with recent developments in neuroscience. Johnson (1999, 2001) suggested that three forces contribute to addictive tendencies: 1) difficulty tolerating affect, 2) object constancy problems leading the addict to see a substance as a soothing internal object substitute, and 3) a biologically based craving resulting from changes in brain functioning. He suggested that the ventral tegmental pathway is critically important in understanding the latter phenomenon because it is the drive pathway that leads animals and human beings to seek water, food, and sex. Johnson noted that this pathway is hijacked by addictive drugs via episodic and irregular drug exposure. Hence drug craving becomes an instance of drive expression. Dynamic psychotherapy would focus on helping patients withstand that desire while looking at the consequences of gratifying it. The ventral tegmental

pathway also activates dreaming, and Johnson noted that the craving for drugs persists in dreams long after the addiction has been resolved. Berridge and Robinson (1995) referred to this "wanting" system as resulting from a sensitization of a specific neuropathway in the brain. They stressed that it operates unconsciously and irrationally to drive the organism to satisfy the "want." In this formulation the fundamental psychoanalytic notion of drives is linked to the experience of the drug addict.

A number of reports from the Veterans Administration–Penn Study (Woody et al. 1983, 1984, 1985, 1986, 1987, 1995) have persuasively demonstrated with rigorous methodology that adding psychotherapy to the overall treatment plan of narcotic-addicted patients produces clear benefits. Narcotic-addicted patients in a methadone maintenance program were randomly assigned to one of three treatment conditions: 1) drug counseling alone with paraprofessionals, 2) expressive-supportive psychotherapy plus drug counseling, or 3) cognitive-behavioral psychotherapy plus counseling. Of 110 patients who completed the full treatment program, those receiving psychotherapy improved considerably more than those who received counseling alone. Expressive-supportive psychotherapy based on dynamic principles resulted in greater improvement in psychiatric symptoms and more success in finding and holding a job than did cognitive-behavioral psychotherapy (Woody et al. 1983). Those patients who were depressed showed the most improvement, followed by patients who had opiate dependency but no other psychiatric disorder. Those with antisocial personality disorder alone did not benefit from psychotherapy (Woody et al. 1985). Patients with antisocial personality disorder improved only when depression was also a symptom.

When the researchers divided the 110 psychotherapy patients into groups according to the severity of their psychiatric symptoms, they noted that patients in the low-severity group made equal progress with counseling or with psychotherapy, whereas patients with a medium degree of severity had better outcomes with treatment plans combining both of these approaches (although some improved just with counseling). However, the group with extremely severe psychiatric symptoms achieved little progress with counseling alone but made considerable progress when psychotherapy was added: at 7-month follow-up, those patients in the group who received psychotherapy used both illicit and prescribed drugs far less often than those who did not receive psychotherapy. These changes were sustained at 12-month follow-up (Woody et al. 1987), even though the subjects were no longer in psychotherapy (the duration of psychotherapeutic treatment was 6 months).

In a partial replication study (Woody et al. 1995), both groups made significant gains in 1 month; by 6-month follow-up, many of the gains made by the drug counseling patients had begun to deteriorate. On the other hand, most of the gains made by the supportive-expressive therapy patients re-

mained or were still evident. All significant differences favored the supportive-expressive psychotherapy group. This comprehensive treatment approach is also highly cost-effective (Gabbard et al. 1997). McLellan et al. (1993) found that adding psychotherapy to standard methadone maintenance treatment led to greater earning power, less welfare income, and strikingly lower hospitalization rates for patients. Woody (2014) concluded that the intensity of psychotherapy needed to produce a treatment effect may vary with the nature of the drug use, the patient's psychiatric problems, and whether pharmacotherapy is used. He also emphasized careful attention to the therapeutic alliance as a key factor in treating patients with these disorders. He noted that the therapist's reactions to the patients must be monitored carefully because of the tendency for these patients to elicit negative and intense responses in the therapists.

Although group therapy is widely used, data confirming its value have only recently emerged. The National Institute on Drug Abuse Cocaine Collaborative Study (Crits-Christoph et al. 1999) examined outpatient treatments of persons who were cocaine dependent. They found that the combination of group therapy and individual therapy or counseling was highly successful in reducing or eliminating cocaine use. The group therapy was provided once weekly, whereas the individual therapy was offered twice weekly and gradually tapered to once weekly. In this population HIV risk must be a major concern taken into account by all therapists. Another benefit of the psychotherapy in this study was that it was associated with a 49% decrease in HIV risk across all treatment, ethnic, and gender groups, primarily based on changes in sexual practice that involved fewer episodes of unprotected sex and fewer sexual partners (Woody et al. 2003).

An individual psychotherapy process is much more likely to be successful in the context of a comprehensive program. Khantzian (1986) suggested the concept of the primary care therapist—an individual who facilitates the addicted patient's involvement with all treatment modalities. The primary care therapist analyzes the patient's resistance to accepting other forms of treatment, such as Narcotics Anonymous (NA) or group therapy, but also provides a holding environment for dealing with the strong affects mobilized in the treatment process. He or she must also participate in treatment decisions involving other modalities. In this model, the emphasis is more supportive than expressive at the beginning of treatment, and the therapist's role is similar to that of a hospital doctor working with an inpatient.

Treece and Khantzian (1986) identified four essential components of a treatment program for mastery of drug dependence: 1) a substitute for the dependency on chemicals (e.g., NA, an alternative system of beliefs, or a benign dependency on a person or religious institution); 2) adequate treatment for other psychiatric disorders, including appropriate psychotropic

medication and psychotherapy; 3) enforced abstinence (e.g., drug antagonists, urine surveillance, probation, drug substitutes such as methadone, external support systems) during a psychological maturational process; and 4) promotion of growth and structural personality change through psychotherapy.

In summary, the indications for expressive-supportive psychotherapy can be conceptualized as the following: 1) serious psychopathology other than drug abuse; 2) engagement in an overall treatment program that includes NA or another support group, enforced abstinence, possibly a drug substitute such as methadone, and appropriate psychotropic medication; 3) no diagnosis of antisocial personality disorder (unless depression is also present); and 4) sufficient motivation to keep session appointments and become engaged in the process. The indications for an expressive or supportive emphasis after the process is well launched are largely determined by the same factors that determine the emphasis in any other psychotherapeutic process (see Table 4–1 in Chapter 4).

Eating Disorders

Eating disorders appear to be conditions of our time. The electronic media bombard us daily with images of slender women who "have it all." The typical eating disorder patient is white, educated, female, economically advantaged, and a product of Western culture (Johnson et al. 1989). Although the eating disorders are commonly divided into anorexia nervosa and bulimia nervosa, the two symptom clusters often overlap in their clinical presentation. Moreover, binge-eating disorder has now been added to the DSM-5 nomenclature as an additional clinical entity in the eating disorders group. In the DSM-5 criteria, one must have persistent episodes of overeating at least once a week marked by loss of control and clinically significant distress. Binge eating is actually common in both bulimia nervosa and binge-eating disorder, but in the case of binge-eating disorder, the recurrent and persistent binge eating occurs in the absence of the usual compensatory behaviors such as food restriction or purging (Marcus and Wildes 2014).

Another way of distinguishing eating disorders from one another is that anorexic individuals are less likely to seek treatment or to continue in treatment programs. Hence, bulimia nervosa and binge-eating disorder can be distinguished by the extent to which change is desired and achieved (Vitousek and Gray 2005). In a study of 103 experienced psychiatrists and psychologists using a cue sort procedure, Westen and Harnden-Fischer (2001) assessed personality functioning in patients who were currently being treated for bulimia or anorexia. Three categories of patients emerged in this study: an

emotionally dysregulated/undercontrolled group, a constricted/overcontrolled group, and a high-functioning/perfectionistic group. These categories appeared to be relevant to etiology, prognosis, and treatment, and the investigators suggested that symptoms were only one component of understanding and treating patients with eating problems. The data also suggested that eating disorder symptoms may be just one expression of a more general pattern of impulse and affect regulation. In other words, for patients in the emotionally dysregulated/undercontrolled group, bulimic symptoms may represent a general impulsivity problem, whereas with a highly perfectionistic and high-functioning type, they may not. In any case, in this chapter the discussions are divided into the traditional categories of anorexia nervosa and bulimia nervosa because principles of treatment and the psychodynamic understanding have generally evolved separately. Readers should keep in mind, however, that in practice one might need to combine principles from the two different entities in the treatment of a particular eating disorder and be guided as well by the overarching features of personality. Comments on the psychodynamic treatment of binge-eating disorder are limited in this chapter because the body of literature on this new disorder is in its early stages.

Anorexia Nervosa

The label *anorexia nervosa* can be misleading, because the word *anorexia* implies that loss of appetite is the central problem. The diagnostic hallmark of anorexia nervosa is actually a fanatical pursuit of thinness related to an overwhelming fear of becoming fat. An arbitrary cutoff of less than 85% of minimal normal body weight for age and height is often used to make the diagnosis. The only major change from the DSM-IV criteria in DSM-5 is that amenorrhea is no longer a required feature of the diagnosis in females. Although 5%–10% of affected individuals are male, their clinical features and psychodynamics are remarkably similar to those of females. Individuals with eating disorders have significantly elevated mortality rates in general, but the highest rates occur with anorexia nervosa (Arcelus et al. 2011). This condition has perhaps the highest rate of mortality of all psychiatric disorders. Hence, treatment must be thoughtfully planned and carefully implemented to assure the survival of the patient. In particular, early intervention, hopefully during adolescence, is optimal because treatment at that age may be more effective than treatment delivered to adults (Crow 2013).

Psychodynamic Understanding

For the past few decades, the seminal contributions of Hilde Bruch (1973, 1978, 1982, 1987) have served as a beacon in the darkness for clinicians

treating anorexic patients. She observed that the preoccupation with food and weight is a relatively late occurrence emblematic of a more fundamental disturbance in self-concept. Most patients with anorexia nervosa have a strong conviction that they are utterly powerless and ineffective. The illness often occurs in "good girls" who have spent their lives trying to please their parents only to suddenly become stubborn and negativistic in adolescence. The body is often experienced as separate from the self, as though it belongs to the parents. These patients lack any sense of autonomy to the point that they do not even feel in control of their bodily functions. The premorbid defensive posture of being a perfect little girl ordinarily defends against a profound underlying feeling of worthlessness.

Bruch traced the developmental origins of anorexia nervosa back to a disturbed relationship between the infant and his or her mother. Specifically, the mother appears to parent the child according to her own needs rather than those of the child. When the child-initiated cues do not receive confirming and validating responses, the child cannot develop a healthy sense of self. Instead, the child experiences herself simply as an extension of her mother, not as a center of autonomy in her own right. Bruch understood the behavior of the anorexic patient as a frantic effort to gain admiration and validation as a unique and special person with extraordinary attributes.

Family therapists, such as Selvini Palazzoli (1978) and Minuchin (Minuchin et al. 1978), have confirmed and elaborated some of the dynamic concepts of Bruch. Minuchin and his colleagues described a pattern of enmeshment in the families of anorexic patients in which there is a general absence of generational and personal boundaries. Each family member is overinvolved in the life of every other family member to the extent that no one feels a sense of separate identity apart from the family matrix. Selvini Palazzoli (1978) also noted that patients with anorexia nervosa have been unable to psychologically separate from their mothers, which results in a failure to achieve any stable sense of their own bodies. The body is thus often perceived as if it were inhabited by a bad maternal introject, and starvation may be an attempt to stop the growth of this hostile, intrusive internal object. Williams (1997) similarly stressed that the parents of an anorexic patient tend to project their anxiety onto their child rather than contain it. These projections may be experienced as inimical foreign bodies within the child. To protect herself from the unmetabolized experiences and fantasies projected onto her by her parents, the young girl may develop a "no entry" system of defenses, concretized by not eating.

The extreme defensive posture of anorexia nervosa suggests that a powerful underlying impulse warrants such a strategy. Indeed, Boris (1984b) noted that intense greed forms the core of anorexia nervosa. Oral desires are so unacceptable, however, that they must be dealt with projectively. Through pro-

jective identification, the greedy, demanding self representation is transferred to the parents. In response to the patient's refusal to eat, the parents become obsessed with whether or not the patient is eating; they become the ones who have desires. In a formulation influenced by Kleinian thinking, Boris conceptualized anorexia nervosa as an inability to receive good things from others because of an inordinate desire to possess. Any act of receiving food or love confronts these patients squarely with the fact that they cannot possess what they desire. Their solution is to not receive anything from anyone. Envy and greed are often closely linked in the unconscious. The patient envies the mother's good possessions—love, compassion, nurturance—but to receive them simply increases the envy. Renouncing them supports the unconscious fantasy of spoiling what is envied, not unlike the fox in Aesop's fable who concluded that the grapes he could not reach were sour. The patient conveys the following message: "There is nothing good available for me to possess, so I will simply renounce all my desires." Such renunciation makes the anorexic patient the object of the desire of others and, in her fantasy, the object of their envy and admiration, because they are "impressed" by her self-control. Food symbolizes their positive qualities that she desires in herself; being enslaved by hunger is preferable to desiring to possess the maternal figure.

Building on the views of Boris, Bromberg (2001) suggested that patients with anorexia nervosa transform desire into renunciation through the mechanism of dissociation. Viewing these patients as growing up lacking a form of human relatedness that allows them to develop self-regulation of affect states, Bromberg suggested that the patient dissociates into separate self states as a way of walling off traumatic experiences and promoting maximal functioning uncontaminated by intense affects. Like Boris, he viewed anorexic patients as enslaved by their inability to contain desire as an affect that can be regulated. They feel they cannot hold desire long enough to make reasonable choices. Hence the issue of who holds the desire in the therapeutic dyad becomes a major issue in treatment.

Most developmental formulations of the origins of anorexia nervosa focus on the mother–daughter dyad. Bemporad and Ratey (1985), however, observed a characteristic pattern of paternal involvement with anorexic daughters. The typical father was superficially caring and supportive but emotionally abandoning of his daughter whenever she truly needed him. In addition, many fathers of anorexic patients seek emotional nurturance from, rather than give it to, their daughters. Both parents often are experiencing serious disappointment in their marriage, leading each parent to seek emotional sustenance from the daughter.

In self psychological terms, the daughter may be treated as a selfobject that provides mirroring and validating functions for each parent but is de-

nied her own sense of self. The child, in turn, cannot rely on human beings to meet her selfobject needs. The anorexic child seriously doubts that parents or any other significant figures in her life will even temporarily give up their own interests and needs to attend to her needs for soothing, affirmation, and mirroring (Bachar et al. 1999). The child may escalate the starvation and restriction in a desperate attempt to force her parents to pay attention to her suffering and recognize her need for help.

To summarize our psychodynamic understanding of anorexia nervosa, the overt behavior of self-starvation is a multiply determined symptom. It is 1) a desperate attempt to be special and unique, 2) an attack on the false sense of self fostered by parental expectations, 3) an assertion of a nascent true self, 4) an attack on a hostile maternal introject viewed as equivalent to the body, 5) a defense against greed and desire, 6) an effort to make others—rather than the patient—feel greedy and helpless, 7) a defensive attempt to prevent unmetabolized projections from the parents from entering the patient, 8) an escalating cry for help to shake the parents out of their self-absorption and make them aware of the child's suffering, and 9) in some cases a dissociative defense into separate self-states as a way of regulating intense affect.

A recent empirical study (Bers et al. 2013) using well-established measures tested the hypothesis that a disrupted relationship with mother and a distorted sense of self are central to anorexia nervosa. Fifteen inpatients diagnosed with anorexia nervosa were compared with a matched sample of 15 psychiatric inpatients without an eating disorder. The findings supported the notion that patients with anorexia nervosa often experience the mother–child relationship as disrupted and have a highly self-critical and defensively overdeveloped sense of self. The researchers also found a common theme of an intense, but well-defended, feeling of neediness in these patients.

These psychodynamic factors are also accompanied by certain characteristic cognitive features, including misperception of one's own body image, all-or-nothing thinking, magical thinking, and obsessive-compulsive thoughts and rituals. The presence of obsessive-compulsive symptoms has led some researchers to wonder whether obsessive-compulsive personality disorder coexists with anorexia nervosa. This assumption is confounded by the notorious unreliability of personality disorder diagnoses in the presence of starvation (Kaplan and Woodside 1987; Powers 1984). Many symptoms, including obsessive-compulsive behavior, appear secondary to starvation. Also, premorbid personality characteristics are accentuated in states of nutritional deficiency. Finally, whether there is truly an elevated prevalence of personality disorders in patients who have anorexia nervosa and bulimia nervosa is not necessarily confirmed by longitudinal follow-up studies of personality disorders (Grilo et al. 2003).

Treatment Approaches

Although controlled studies have suggested that cognitive-behavioral therapy and interpersonal therapy can be useful treatments for bulimia nervosa and binge-eating disorder, the evidence base available for the psychotherapy of anorexia nervosa is much weaker (Marcus and Wildes 2014). A recent randomized controlled trial known as the Anorexia Nervosa Treatment of Out-Patients (ANTOP) study (Zipfel et al. 2013) compared three treatments for anorexia nervosa: 80 patients received focal psychodynamic therapy, 80 received enhanced cognitive-behavioral therapy, and 82 received optimized treatment as usual. Focal psychodynamic therapy proved advantageous in terms of recovery at 12-month follow-up, and enhanced cognitive-behavioral therapy was more effective with respect to speed of weight gain and improvements in eating disorder psychopathology. At the end of treatment, body mass index had increased in all groups. Hence, this investigation is encouraging regarding the role of the psychotherapies in the treatment of anorexia nervosa.

A meta-analysis (Couturier et al. 2013) suggested that family-based treatment for adolescents with anorexia nervosa is probably superior to individual treatment and could be recommended as the first line of treatment. With young adults, it is often difficult to arrange family involvement, and various strategies of individual psychotherapy have been tried. In general, one must be aware that treatments for anorexia nervosa are not necessarily effective, and the therapist must be willing to be innovative and creative in approaching patients with this disorder. In one randomized controlled trial comparing supportive clinical management with specialized forms of cognitive-behavioral therapy and interpersonal therapy, the supportive clinical management was superior to both of the more specialized therapies (McIntosh et al. 2005).

Clinicians who treat patients with anorexia nervosa are in consensus that the treatment goals must not be focused narrowly on weight gain (Boris 1984a, 1984b; Bruch 1973, 1978, 1982, 1987; Chessick 1985; Dare 1995; Hsu 1986; Hughes 1997; Powers 1984). A "two-track" approach, advocated by Garner et al. (1986), includes a first step of restoration of eating for weight gain. Once this step is accomplished, the second step of psychotherapeutic intervention can begin. Anorexic patients show much greater improvement when provided with a mixture of family therapy and dynamic individual therapy than when they are simply managed with educational measures designed to control weight (Dare 1995; Hall and Crisp 1983). Long-term, individual expressive-supportive psychotherapy is the cornerstone of the treatment. Unless the patient's underlying disturbance of the self and the associated distortions of internal object relations are addressed, the

patient will follow a course of repeated relapse and revolving-door hospital admissions (Bruch 1982). For those patients living at home, family therapy may be a valuable adjunct to individual therapy. Although some patients appear to benefit from group psychotherapy (Lieb and Thompson 1984; Polivy 1981), the limited data suggest that of those who benefit, most do not have associated personality disorders (Maher 1984).

Most psychodynamic clinicians combine their treatment of anorexia nervosa with techniques borrowed from other models to address false beliefs, nutritional issues, and family difficulties (Vitousek and Gray 2005). Saving the patient's life exceeds in importance any fidelity to a favorite theoretical approach. Hence hospitalization is frequently used in the course of individual psychotherapy. Although no indications for inpatient treatment are universally agreed on, a weight loss of 30% of normal body weight is a good rule of thumb to use in determining whether inpatient treatment is necessary (Garfinkel and Garner 1982). Approximately 80% of all anorexic patients will gain weight with hospital treatment (Hsu 1986), provided that the hospital staff can create a specific milieu. As described in Chapter 6, the hospital staff must be wary of the patient's unconscious efforts to reenact the family struggle in the hospital milieu. They must convey an interest in helping the patient restore weight without becoming excessively concerned about it and without making demands similar to those the patient's parents would make. The patient can be helped to cope with the fear of losing control by arranging an eating plan of frequent but small meals with a member of the nursing staff who is available to discuss the patient's anxiety about eating. Weight gains should be reported to the patient with concomitant positive reinforcements. Any surreptitious vomiting or purging should be confronted and controlled with structural measures such as locking the bathroom door. Members of the treatment staff may need to reassure the patient that they will not allow too much weight gain, thus helping the patient develop a sense of trust in them.

Brief hospitalizations are rarely curative, nor are treatment programs that demand a normal average weight and then ignore the intense anxiety aroused by such a demand (Bruch 1982). At least 50% of the patients who successfully control their anorexia nervosa with inpatient treatment will relapse within 1 year (Hsu 1980). For the 20% who do not respond to brief hospitalization, extended hospitalization may be indicated.

Individual expressive-supportive psychotherapy often takes several years of painstaking work because of the formidable resistance posed by the anorexic patient. Four guiding principles of technique are useful (Table 12–1).

1. *Avoid excessive investment in trying to change the eating behavior.* As Boris (1984b) observed, "What we call their symptoms they call their salva-

TABLE 12–1. Technical guidelines in the psychotherapy of anorexic patients

Avoid excessive investment in trying to change the eating behavior.
Avoid interpretations early in the therapy.
Carefully monitor countertransference.
Examine cognitive distortions.

tion" (p. 315). The patient views anorexia nervosa as the solution to an internal problem. Psychotherapists who immediately define it as a problem that must be changed reduce their chances of forming a viable therapeutic alliance. The behavior associated with anorexia nervosa elicits demands and expectations for change from the patient's parents. Through projective identification, the therapist is likely to experience powerful pressure to identify with the patient's projected internal objects that are associated with the parents. Instead of acting on that pressure and becoming a parental figure, the therapist must try to understand the patient's internal world. One form of this reenactment is the equation of eating with talking. Just as the patient provokes her parents by refusing to eat, she will attempt to provoke the therapist by refusing to talk (Mintz 1988). At the beginning of the therapy, it may thus be helpful to clarify that the primary goal of the treatment is to understand the patient's underlying emotional disturbance rather than the problem of not eating (Bruch 1982; Chessick 1985). Therapists must acknowledge the patient's experience that the self-discipline associated with anorexia nervosa is in some way an achievement (Bromberg 2001) while at the same time pointing out that the capacity for thinking and communicating improves with nutritional improvement.

2. *Avoid interpretations early in the therapy.* Interpretations of unconscious wishes or fears will be experienced by the anorexic patient as a repetition of her life story. Someone else is telling her what she really feels, while her conscious experience is minimized and invalidated. Rather, the therapist's task should be to validate and empathize with the patient's internal experience (Bruch 1987; Chessick 1985). The therapist should take an active interest in what the patient thinks and feels, conveying the message that the patient is an autonomous person entitled to her own ideas about her illness. Of major importance is helping the patient define her own feeling states. The actions and decisions stemming from these feelings must be legitimized and respected. The therapist can help the patient explore various options but should refrain from telling her what to do (Chessick 1985). This empathic, ego-building, supportive approach in the early phases of therapy will facilitate introjection of the therapist

as a benign object. Bruch (1987) suggested emphasizing the positive and conceptualizing the therapy as an experience in which patients will discover their positive qualities. She acknowledged that her approach has many similarities to Kohut's (1984) self psychological approach. Chessick (1985) shared this view that insight into unconscious conflict is unlikely to be curative with these patients. Although slightly more optimistic about the use of interpretations, Boris (1984a) recommended withholding interpretations until the patient finds herself. Even then, he advocated talking "to the air" instead of directly to the patient, thereby providing some distance in the relationship and respecting her boundaries. Such interpretations should be delivered as hypotheses, as though talking to an imaginary colleague rather than as making a definitive pronouncement directly to the patient.

3. *Carefully monitor countertransference.* Anorexic patients commonly believe that their parents want them to gain weight so that other people will not view the parents as failures (Powers 1984). The therapist is likely to become anxious about similar matters. Therapists who work within the framework of a comprehensive treatment team, in particular, may begin to feel that others are negatively judging their work if their patients fail to gain weight. This countertransference concern may lead the therapist to fall into the trap of identifying with the patient's parents. The ideal situation for individual psychotherapy is for another treater to monitor weight gain, leaving the therapist free to explore the patient's underlying psychological issues. When hospitalization is required for weight control, the admitting psychiatrist can manage food intake while the psychotherapist continues the psychotherapeutic work in the hospital. In this setting, the psychotherapist can work productively with the team.

   Hughes (1997) beautifully described some of the typical countertransference dilemmas confronted in the treatment of patients with anorexia nervosa. Just as the patient keeps the parents involved in trying to help but always failing, she also engages the therapist in that role. Frequently, the patient presents herself as wanting to cooperate with treatment but then sabotages the therapist's help. With anorexia patients, the therapeutic alliance is typically much more tenuous than it appears, and the therapist must cope with the frustration of feeling duped by the patient. In handling the countertransference, it is useful to remember that the patient understands progress as equivalent to separation from family and growing up, both of which are highly threatening. Anxiety is stirred up in the therapist by the patient's flirtation with death, which is made all the more frustrating because of the patient's frequent denial of suicidal wishes. Just as families may get exhausted and angry and even develop unconscious murderous wishes toward the anorexic patient, the thera-

pist may also experience despair, murderous rage, and a sense that no one else fully appreciates the lethality of the patient.

4. *Examine cognitive distortions.* Misperceptions of body size and illogical cognitive beliefs should be explored with the patient nonjudgmentally. Vitousek and Gray (2005) stressed the similarity between Bruch's approach challenging illogical conclusions and false assumptions to currently accepted principles of cognitive therapy. Clearly, the psychotherapist must assume an educative role with these patients, helping them understand the effects of starvation on cognition. However, the therapist must seek to educate while making no demand for change. Alternatively, the therapist can simply explore the consequences of the patient's choices.

These technical guidelines, while useful, are not to be taken as a "cookbook" formula for the psychotherapy of anorexic patients. Therapists must be flexible, persistent, and stable in the face of the patient's tendency to "wait out" the therapy process until she can once again be left alone. Body image distortions, which often approach delusional proportions, may be particularly refractory to educational and therapeutic efforts. Therapists must be wary of countertransference despair and frustration that might lead them to attempt to force the patient to "see things as they really are."

Although patients' anorexia nervosa may seem highly treatment resistant in the short run, many patients ultimately improve. In one long-term follow-up study (Sullivan et al. 1998), only 10% of patients followed up a mean of 12 years after initial referral still met the criteria for anorexia nervosa. However, many still struggled with some of the features of the illness, including perfectionism and a relatively low body weight. On the other hand, in a review of 300 patients in four different series, Hsu (1991) calculated that about 1 in 7, or 14% of the patients, had subsequently died from suicide or complications of the illness. In a 5-year follow-up comparison of family therapy and individual supportive therapy (Eisler et al. 1997), both treatments had produced significant improvements. Patients with early onset and a short history of anorexia nervosa appeared to do better with family therapy, whereas those with late onset appeared to do better with individual supportive therapy. In a review of all treatment studies, Vitousek and Gray (2005) concluded that for adult anorexic patients, no intervention of any kind, medication or psychotherapy, is that effective in patients who have this highly treatment-resistant disorder.

Bulimia Nervosa

Patients with bulimia nervosa are generally distinguished from those with anorexia nervosa on the basis of relatively normal weight and the presence

of binge eating and purging. Emaciated patients who are also binge eating and purging are often classified as anorexics, bulimic subgroup (Hsu 1986). Accumulating data suggest considerable linkage between the two disorders (Garner et al. 1986). At least 40%–50% of all anorexic patients also have bulimia (Garfinkel et al. 1980; Hall et al. 1984; Hsu et al. 1979). Long-term follow-up data suggest that over a long period of time, anorexia nervosa may give way to bulimia nervosa, but the reverse pattern is much rarer (Hsu 1991). Bulimia nervosa also varies according to the personality dimensions involving impulse control and affect regulation identified by Westen and Harnden-Fischer (2001). Comorbidity may also have a profound impact.

As Yager (1984) eloquently observed,

> Bulimia is not a disease. Nor is it a simple habit. Bulimia is heterogeneous and, like pneumonia, it may result from a variety of causes. I have found it useful to conceptualize bulimia as a habit or behavioral pattern embedded in a personality, in turn embedded in a biology, and all this embedded in a culture in which bulimia seems to be developing at an increasing rate. (p. 63)

Psychodynamic Understanding

When considering the psychodynamics of bulimia, therapists must keep in mind this heterogeneity. The various contributors to our dynamic understanding of bulimia are likely to be analogous to the proverbial blind men reporting their perceptions of an elephant based on their particular vantage points. As always, dynamic understanding must be individualized. A clinical picture of bulimia may be observed in patients with vastly different character structures, ranging from psychotic through borderline to neurotic (Wilson 1983). Anorexia and bulimia are essentially opposite sides of the same coin (Mintz 1988). Whereas the anorexic patient is characterized by both greater ego strength and greater superego control, some bulimic patients may have a generalized inability to delay impulse discharge based on a weakened ego and a lax superego. Binge eating and purging are not necessarily isolated impulse problems; rather, they may coexist with impulsive, self-destructive sexual relationships and with polydrug abuse.

Some empirical evidence suggests which psychodynamic factors might be at work in patients with bulimia nervosa. In a multivariate genetic analysis, Kendler et al. (1995) found that family and environmental factors play key roles in the development of the disorder. In a community-based case-control study involving 102 subjects with bulimia nervosa and 204 healthy control subjects (Fairburn et al. 1997), parental problems, sexual or physical abuse, and negative self-evaluation were all associated with the development of the illness. The investigators suggested that negative self-evaluation might encourage dieting by distorting the girls' views of their appearance.

These empirical findings are supported by observations stemming from psychoanalytic treatment. Reich and Cierpka (1998) found disturbances in the emotional dialogue between the bulimic patients and their parents and a consistent pattern of conflict between contradictory parts of the self that was undoubtedly influenced by conflicting identifications with parents. These authors also suggested that many bulimic patients experience a lack of respect for boundaries and a tactless intrusion into their privacy, which would apply to both sexual abuse and psychological abuse. Reich and Cierpka noted that these patients frequently used defenses involving reversal of affects and turning passive to active, and they also experienced contradictory superego demands.

Those authors who have studied the developmental origins of bulimia have identified extensive difficulty with separation both in the parents and in the individual patient. A common theme in the developmental history of bulimic patients is the absence of a transitional object, such as a pacifier or blanket, to help the child separate psychologically from her mother (Goodsitt 1983). This developmental struggle to separate may be played out instead by using the body itself as a transitional object (Sugarman and Kurash 1982), with the ingestion of food representing a wish for symbiotic merger with the mother and the expulsion of food an effort at separation from her. Like the mothers of anorexic patients, the parents of children who grow up to be bulimic often relate to their children as extensions of themselves (Humphrey and Stern 1988; Strober and Humphrey 1987). These children are used as selfobjects to validate the self of the parent. Each member of the family depends on all the other members to maintain a sense of cohesion. Although this pattern characterizes the families of anorexic patients, a particular mode of managing unacceptable "bad" qualities is predominant in bulimic families. The bulimic family system apparently involves a strong need for everyone to see themselves as "all good." Unacceptable qualities in the parents are often projected onto the bulimic child, who becomes the repository of all "badness." By unconsciously identifying with these projections, she becomes the carrier of all the family's greed and impulsivity. The resulting homeostatic balance keeps the focus on the "sick" child rather than on conflicts within or between the parents.

The psychodynamic observations about difficulties with separation in bulimic patients have been confirmed by empirical research (Patton 1992). Forty patients with eating disorders were compared with a control group of 40 women with normal eating patterns to see how they would respond to subliminal or supraliminal stimuli. Each group was shown an abandonment or a control stimulus at exposure durations that were either subliminal or supraliminal. Following exposure to an abandonment stimulus, the group with eating disorders ate significantly more crackers than did subjects in the

control group. The investigators concluded that binge eating was indeed a defense against an unconscious fear of abandonment.

In many instances, then, bulimic patients concretize the object relations mechanisms of introjection and projection. Ingestion and expulsion of food may directly reflect the introjection and projection of aggressive, or "bad," introjects. In many cases, this splitting process is further concretized by the patient. She may regard protein as "good" food, which is therefore retained rather than purged, and carbohydrates or junk food as "bad" food, which is consumed in huge quantities, only to be regurgitated. On the surface, this strategy of managing aggression may be compelling—the expulsion of badness in the form of vomit leaves the patient feeling good. However, the residual feeling of "goodness" is unstable because it is based on splitting, denial, and projection of aggression rather than on integration of the bad with the good.

Treatment Considerations

The most important single principle in the treatment of bulimia is individualization of the treatment plan. Concurrent psychiatric disorders, such as depression, personality disorders, and drug abuse, should be addressed as part of comprehensive treatment planning. "Assembly line treatment programs" (Yager 1984) that treat all bulimic patients alike will only help a fraction of them because of a failure to recognize and appreciate the inherent heterogeneity of the bulimic population. About one-third of all bulimic patients represent a relatively healthy subgroup who will respond well to a time-limited approach involving brief cognitive-behavioral therapy and a psychoeducational program (Johnson and Connors 1987; Johnson et al. 1989). Support groups such as Overeaters Anonymous (OA) may also sustain this subgroup of patients without further treatment.

In a review of 88 studies conducting follow-up assessments with bulimic subjects, Keel and Mitchell (1997) found that approximately 50% of women had fully recovered from the disorder 5–10 years after presentation. However, 20% continued to meet full criteria for bulimia nervosa, and approximately 30% had relapsed into bulimic symptoms. Patients who achieved complete abstinence from bingeing and purging with a 16-week trial of cognitive-behavioral therapy were followed up 4 months after treatment, and the investigators determined that 44% of the patients had relapsed (Halmi et al. 2002). A review of studies using cognitive-behavioral therapy for bulimia nervosa reflects how difficult it is to treat these patients. Among the half or more of patients who do not attain full recovery through this approach, results suggest that bingeing continues at an average rate of 2.6 times per week and purging at a rate of 3.3 times per week at treatment termination

(Thompson-Brenner et al. 2003). Longitudinal assessments of mortality over 8–25 years (Crow et al. 2009) suggest that there are disconcertingly high mortality rates for bulimia nervosa, close to those for anorexia nervosa. Moreover, although there has been some success treating bulimia nervosa with cognitive-behavioral therapy and interpersonal therapy, community clinicians infrequently use evidence-based psychotherapy when treating their patients with eating disorders (von Ranson et al. 2013). Psychodynamic psychotherapy is largely untested.

Although dynamic approaches may not be indicated or necessary for all patients, they still may benefit the majority. Among nonresponders, as many as two-thirds may have borderline personality disorder (Johnson et al. 1989), whereas others may have other personality disorders or significant depression. These patients may require long-term, expressive-supportive psychotherapy and often need psychopharmacological intervention as well. Many patients also frankly resent a behavioral approach to their bulimic symptoms (Yager 1984). Focusing on the patient's overt behavior while neglecting her internal world may recapitulate the patient's experience of growing up with parents who are more concerned about surface than substance. Yager (1984) suggested that as many as 50% of all bulimic patients are dissatisfied with behavior modification techniques. Some patients will even experience the task of writing a daily diary about their eating habits as demeaning, because they may view their eating problems as symptomatic of more fundamental disturbances. Treatment that does not match the patient's interests and belief system is doomed to failure (Yager 1984).

Bulimia nervosa can be life threatening. Patients have been known to alter their electrolyte balance sufficiently to precipitate cardiac arrest. Blood chemistry monitoring should therefore be part of the outpatient management of these patients, with hospitalization as a backup strategy. Because many bulimic patients also have borderline personality disorder or major affective disorders, hospitalization may be required in the face of a suicide attempt or severe self-mutilation. The hospital treatment must follow an individualized comprehensive treatment plan, in addition to the task of gaining symptom control through locking bathrooms, implementing a normal meal schedule, providing psychoeducational assistance from a dietitian, and encouraging the keeping of a diary. Hospitalization often provides the therapist with an opportunity to better understand the patient's internal object relations; thus, it facilitates more sophisticated diagnostic understanding and more precise treatment planning:

> Ms. W was a 19-year-old college student with a mixture of bulimic and anorexic symptoms. She was hospitalized after "firing" her psychotherapist and completely losing control of her binge eating and purging. Her parents, who

were quite exasperated with her behavior, brought her to the hospital because they felt hopeless about ever getting her to eat properly. During the first week of hospitalization, Ms. W informed her hospital doctor that she planned to remain aloof and distant because she did not want to get attached to a doctor again only to be disappointed. Regular meals and group meetings were immediately implemented, but the patient refused to go to meals or to attend the group. She insisted that she was capable of dieting only by eating when and what she wanted. She pointed out to her doctor that her weight was remaining constant, so there was no need for concern.

The nursing staff became increasingly irritated with Ms. W for her utter lack of cooperation. The more stubborn and resistant the patient became, the more the staff insisted that she follow the structure of the hospital program. In one staff meeting, the hospital doctor observed that the patient had succeeded in recapitulating her family situation. By asserting that she should have control over her diet, she provoked others into attempting to take control of her eating. She could then feel victimized by the controlling forces around her, just as she felt victimized by her parents.

Ms. W's doctor met with her and pointed out to Ms. W that she was attempting to provoke the hospital staff into a reenactment of her family situation. She asked the patient to reflect on what she might gain from this reenactment. Ms. W responded by indicating to her doctor that she was not interested in talking. Three days later, she told her doctor that she had been hoarding medications and sharp objects in a locked drawer in her hospital room so that she might attempt suicide. She said that she had decided to tell her doctor because she really did not want to die. She also indicated that it was terribly difficult for her to communicate feelings to her doctor because she believed that she would become uncontrollably dependent and would lose any sense of her own self. She was certain that dependency on her doctor would lead to her being exploited and mistreated according to the doctor's needs rather than her own treatment needs.

This information helped the hospital staff understand Ms. W's resistance to the treatment structure. By refusing to cooperate, this patient was attempting to establish a sense of self independent of the demands and expectations of others. Cooperation with the nursing staff and collaboration with her hospital doctor carried the risk that she would become a mere extension of others, as she had in her family. Once this underlying anxiety surfaced, the staff members allowed Ms. W to have more say in her eating program. With a member of the nursing staff, she was able to collaborate on and then follow a program that was acceptable to both of them.

Just when Ms. W seemed to be improving, however, her hospital doctor received a call at home on Christmas morning as her family was opening presents. A hospital nurse was calling to inform her that Ms. W had smuggled in and then taken a large number of laxatives and had been having diarrhea all morning. The nurse was worried that Ms. W might require emergency medical treatment, so Ms. W's doctor felt compelled to go to the hospital to see the patient. Two days later, when Ms. W was medically stable, her doctor confronted her about the transference hostility involved in her purging, then suggested that perhaps Ms. W had wished to spoil her doctor's Christmas morning. Although the patient blandly denied any such possibil-

ity, her doctor had to suppress intense anger at Ms. W for the timing of her acting-out. It gradually dawned on the doctor that the act of purging had enabled the patient to expel her own aggression. As a result, she could not relate to the doctor's interpretation of her act as hostile; the doctor unconsciously served as a container of the patient's projected anger.

Although this case illustrates a more refractory patient with borderline personality disorder as part of the clinical picture, the transference-countertransference struggles are not atypical of what individual therapists commonly encounter with bulimic patients. Therapists may find themselves repeatedly provoked into accepting the "badness" the patient is attempting to expel. They may also feel "vomited on" when the patient repeatedly spits back at them all their therapeutic efforts. The recapitulation of the family pattern in hospital treatment or in individual psychotherapy helps the clinician understand the patient's role within the family system. Because bulimia is so often part of a homeostatic balance in the family, family therapy or family intervention in association with individual therapy is frequently needed. By ignoring the family system, the therapist runs the risk that the patient's improvement will be terribly threatening to other family members. Defensive reactions to this threat may include an insidious undermining of the bulimic patient's treatment or the development of a serious dysfunction in another family member. The family's need for the bulimic patient's illness must be respected, and the parents must feel "held" and validated so that they will not sabotage the treatment (Humphrey and Stern 1988).

Because of their intense ambivalence and their concern about upsetting the family equilibrium, many bulimic patients will try to avoid intensive psychodynamic therapy. They may consider themselves to be defective, and psychotherapeutic exploration involves a risk that this defectiveness will be exposed (Reich and Cierpka 1998). Introducing an eating diary and pointing out the association between certain eating patterns and emotional states may be an extremely effective way to build a therapeutic alliance with the patient. One of the common countertransference difficulties encountered is the desire to cure the patient quickly, which leads the therapist to begin "overfeeding" the patient by introducing too many interpretive interventions too soon. As Reich and Cierpka (1998) cautioned, interpretations and confrontations may be handled in a bulimic way by greedily consuming but not properly digesting them. Although in most quarters cognitive-behavioral therapy has become the preferred psychotherapeutic approach to bulimia nervosa, psychodynamic therapy still has a role to play. In a carefully designed study comparing cognitive-behavioral therapy and dynamic therapy, the initial results favored the former, but in a longer follow-up period both forms of therapy were approximately equal in their effectiveness (Fairburn et al. 1995).

Dynamic group psychotherapy may also be a useful adjunctive treatment. A growing empirical literature testifies to the efficacy of group psychotherapy for patients with bulimia nervosa (Harper-Giuffre et al. 1992; Liedtke et al. 1991; Mitchell et al. 1990). In a review of 18 different reports of this modality with bulimic patients in an outpatient setting, Oesterheld et al. (1987) found reason for guarded optimism. The consensus was that group psychotherapy effectively reduced bulimic symptoms by an average of 70%. However, these figures appear inflated because most studies excluded dropouts from their calculations. Dropout rates tended to be high even though most groups had excluded patients with borderline personality disorder and other severe character pathology. Long-term follow-up data were also lacking. The group therapists appeared to agree, much as did the individual therapists, that a stable remission requires both insight and symptom control. In a randomized controlled trial of psychoanalytic group therapy and psychoeducation for a group of patients with binge-eating disorder, most patients in both groups were without eating disorders and had a lower rate of binge episodes (Ciano et al. 2002). In the analytic group therapy patients, these gains were mostly sustained at 6- and 12-month follow-up.

In summary, the indication for a dynamic approach to bulimia nervosa is a lack of response to time-limited psychoeducational and cognitive-behavioral methods. Family interventions in the form of support, education, and possibly family therapy are also generally necessary. Some form of symptom control is required in conjunction with the other approaches. Brief hospitalization, support groups such as OA, and group psychotherapy can all assist the patient with symptom control. Some individual psychotherapists also consider symptom control as part of the treatment process. A substantial subset of bulimic patients with associated severe character pathology, suicidal tendencies, and propensities toward life-threatening electrolyte disturbances will require psychotherapy in the context of long-term hospitalization. These patients defy the most diligent efforts of treaters to structure their lives. They seem bent on a self-destructive course that may indeed be fatal without extended hospital treatment.

Binge-Eating Disorder

As noted earlier, there is far less research on the treatment of binge-eating disorder than the other eating disorders. However, the prevalence in community samples is as high as 3.5% (Hudson et al. 2007). These individuals tend to report more fear of gaining weight and more body dissatisfaction compared with those obese individuals who do not binge eat. Moreover, they tend to continue to gain weight throughout their lives (Fairburn et al. 2000). Therapists must struggle with countertransference contempt evoked by

someone who appears to engage in self-indulgence without concern for consequences and countertransference hopelessness regarding the effectiveness of one's treatment efforts. Insecure attachment has been found in all eating disorders, including binge-eating disorder (Abbate-Daga et al 2010). In fact, attachment insecurity is directly correlated with body dissatisfaction. In a comparison study of group psychodynamic interpersonal psychotherapy and group cognitive-behavioral therapy (Tasca et al. 2006), both forms of group therapy reduced binge eating, and the results indicated that individual outcomes differed across treatments on the basis of the level of attachment anxiety and avoidance. More research is needed to refine the psychodynamic understanding and treatment of these patients.

References

Abbate-Daga G, Gramaglia C, Amianto F, et al: Attachment insecurity, personality, and body dissatisfaction in eating disorders. J Nerv Ment Dis 198:520–524, 2010

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Arcelus J, Mitchell AJ, Wales G, et al: Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. Arch Gen Psychiatry 68:724–731, 2011

Bachar E, Latzer Y, Kreitler S, et al: Empirical comparison of two psychological therapies—self psychology and cognitive orientation—in the treatment of anorexia and bulimia. J Psychother Pract Res 8:115–128, 1999

Balint M: The Basic Fault: Therapeutic Aspects of Regression. New York, Brunner/Mazel, 1979

Bemporad JR, Ratey J: Intensive psychotherapy of former anorexic individuals. Am J Psychother 39:454–466, 1985

Berridge KC, Robinson T: The mind of an addictive brain: neural sensitization of wanting versus liking. Current Directions in Psychological Science 4:71–76, 1995

Bers SA, Besser A, Harpaz-Rotem I, et al: An empirical exploration of the dynamics of anorexia nervosa: representations of self, mother, and father. Psychoanalytical Psychology 30:188–209, 2013

Blatt SJ, McDonald C, Sugarman A, et al: Psychodynamic theories of opiate addiction: new directions for research. Clin Psychol Rev 4:159–189, 1984a

Blatt SJ, Rounsaville B, Eyre SL, et al: The psychodynamics of opiate addiction. J Nerv Ment Dis 172:342–352, 1984b

Boris HN: On the treatment of anorexia nervosa. Int J Psychoanal 65:435–442, 1984a

Boris HN: The problem of anorexia nervosa. Int J Psychoanal 65:315–322, 1984b

Brent D, Melhem N, Donohoe MD, et al: The incidence and course of depression in bereaved youth 21 months after the loss of a parent to suicide, accident, or sudden natural death. Am J Psychiatry 166:786–794, 2009

Bromberg PM: Treating patients with symptoms—and symptoms with patience: reflections on shame, dissociation, and eating disorders. Psychoanalytic Dialogues 11:891–912, 2001

Brown S: Treating the Alcoholic: A Developmental Model of Recovery. New York, Wiley, 1985

Bruch H: Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within. New York, Basic Books, 1973

Bruch H: The Golden Cage: The Enigma of Anorexia Nervosa. Cambridge, MA, Harvard University Press, 1978

Bruch H: Psychotherapy in anorexia nervosa. Int J Eat Disord 1:3–14, 1982

Bruch H: The changing picture of an illness: anorexia nervosa, in Attachment and the Therapeutic Process. Edited by Sacksteder JL, Schwartz DP, Akabane Y. Madison, CT, International Universities Press, 1987, pp 205–222

Casillas A, Clark LA: Dependency, impulsivity, and self-harm: traits hypothesized to underlie the association between Cluster B personality and substance use disorders. J Pers Disord 16:424–436, 2002

Chessick RD: Clinical notes toward the understanding and intensive psychotherapy of adult eating disorders. Annual of Psychoanalysis 22/23:301–322, 1985

Ciano R, Rocco PL, Angarano A, et al: Group-analytic and psychoeducational therapies for binge-eating disorder: an exploratory study on efficacy and persistence of effects. Psychotherapy Research 12:231–239, 2002

Compton WM, Thomas YF, Stinson FS, et al: Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States. Arch Gen Psychiatry 64:566–576, 2007

Cooper DE: The role of group psychotherapy in the treatment of substance abusers. Am J Psychother 41:55–67, 1987

Cornelius JR, Salloum IM, Mezzich J, et al: Disproportionate suicidality in patients with comorbid major depression and alcoholism. Am J Psychiatry 152:358–364, 1995

Couturier J, Kimber M, Szatmari P: Efficacy of family-based treatment for adolescents with eating disorders: a systematic review and meta-analysis. Int J Eat Disord 46:3–11, 2013

Crits-Christoph P, Siqueland L, Blaine J, et al: Psychosocial treatments for cocaine dependence: results of the National Institute on Drug Abuse Cocaine Collaborative Study. Arch Gen Psychiatry 56:493–501, 1999

Crow S: Eating disorders and risk of death. Am J Psychiatry 170:824–825, 2013

Crow SJ, Peterson CB, Swanson SA, et al: Increased mortality in bulimia nervosa and other eating disorders. Am J Psychiatry 166:1342–1346, 2009

Dare C: Psychoanalytic psychotherapy, in Treatments of Psychiatric Disorders, 2nd Edition, Vol 2. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1995, pp 2129–2152

Dodes LM: Abstinence from alcohol in long-term individual psychotherapy with alcoholics. Am J Psychother 38:248–256, 1984

Dodes LM: The psychology of combining dynamic psychotherapy and Alcoholics Anonymous. Bull Menninger Clin 52:283–293, 1988

Dodes LM: Addiction, helplessness, and narcissistic rage. Psychoanal Q 59:398–419, 1990

Donovan JM: An etiologic model of alcoholism. Am J Psychiatry 143:1–11, 1986

Eisler I, Dare C, Russell GF, et al: Family and individual therapy in anorexia nervosa: a 5-year follow-up. Arch Gen Psychiatry 54:1025–1030, 1997

Fairburn CG, Norman PA, Welch SL, et al: A prospective study of outcome and bulimia nervosa and the long-term effects of three psychological treatments. Arch Gen Psychiatry 52:304–312, 1995

Fairburn CG, Welch SL, Doll HA, et al: Risk factors for bulimia nervosa: a community-based case-control study. Arch Gen Psychiatry 54:509–517, 1997

Fairburn CG, Cooper Z, Doll HA, et al: The natural course of bulimia nervosa and binge eating disorder in young women. Arch Gen Psychiatry 57:659–665, 2000

Frances RJ, Mack AH, Borg L, et al: Psychodynamics, in The American Psychiatric Publishing Textbook of Substance Abuse Treatment, 3rd Edition. Edited by Galanter M, Kleber H. Washington, DC, American Psychiatric Publishing, 2004, pp 337–352

Gabbard GO, Lazar SG, Hornberger J, et al: The economic impact of psychotherapy: a review. Am J Psychiatry 154:147–155, 1997

Garfinkel PE, Garner DM: Anorexia Nervosa: A Multidimensional Perspective. New York, Brunner/Mazel, 1982

Garfinkel PE, Moldofsky H, Garner DM: The heterogeneity of anorexia nervosa: bulimia as a distinct subgroup. Arch Gen Psychiatry 37:1036–1040, 1980

Garner DM, Garfinkel PE, Irvine MJ: Integration and sequencing of treatment approaches for eating disorders. Psychother Psychosom 46:67–75, 1986

Goodsitt A: Self-regulatory disturbances in eating disorders. Int J Eat Disord 2:51–60, 1983

Goodwin DW: Alcoholism and heredity. Arch Gen Psychiatry 36:57–61, 1979

Gorton GE, Akhtar S: The relationship between addiction and personality disorder: reappraisal and reflections. Integrative Psychiatry 10:185–198, 1994

Grant BF, Stinson FS, Dawson BA, et al: Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 61:361–368, 2004

Grilo CM, Sanislow CA, Skodol AE, et al: Do eating disorders co-occur with personality disorders? Comparison groups matter. Int J Eat Disord 33:155–164, 2003

Hall A, Crisp AH: Brief psychotherapy in the treatment of anorexia nervosa: preliminary findings, in Anorexia Nervosa: Recent Developments in Research. Edited by Darby PL, Garfinkel PE, Garner DM, et al. New York, Alan R Liss, 1983, pp 427–439

Hall A, Slim E, Hawker F, et al: Anorexia nervosa: long-term outcome in 50 female patients. Br J Psychiatry 145:407–413, 1984

Halmi KA, Agras WS, Mitchell J, et al: Relapse predictors of patients with bulimia nervosa who achieved abstinence through cognitive behavioral therapy. Arch Gen Psychiatry 59:1105–1109, 2002

Harper-Giuffre H, MacKenzie KR, Sivitilli D: Interpersonal group psychotherapy, in Group Psychotherapy for Eating Disorders. Edited by Harper-Giuffre H, MacKenzie KR. Washington, DC, American Psychiatric Press, 1992, pp 105–145

Hasin D, Fenton MC, Skodal A, et al: Personality disorders and the 3-year course of alcohol, drug, and nicotine use disorders. Arch Gen Psychiatry 68:1158–1167, 2011

Hasin D, O'Brien CP, Auriacombe M, et al: DSM-5 criteria for substance use disorders: recommendations and rationale. Am J Psychiatry 170:834–851, 2013

Hsu LK: Outcome of anorexia nervosa: a review of the literature (1954 to 1978). Arch Gen Psychiatry 37:1041–1046, 1980

Hsu LK: The treatment of anorexia nervosa. Am J Psychiatry 143:573–581, 1986

Hsu LK: Outcome studies in patients with eating disorders, in Psychiatric Treatment: Advances in Outcome Research. Edited by Mirin SM, Gossett JT, Grob MC. Washington, DC, American Psychiatric Press, 1991, pp 159–180

Hsu LK, Crisp AH, Harding B: Outcome of anorexia nervosa. Lancet 1:61–65, 1979

Hudson JI, Hiripi E, Pope HG, et al: The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry 61:348–358, 2007

Hughes P: The use of the countertransference in the therapy of patients with anorexia nervosa. European Eating Disorders Review 5:258–269, 1997

Humphrey LL, Stern S: Object relations and the family system in bulimia: a theoretical integration. J Marital Fam Ther 14:337–350, 1988

Johnson B: Three perspectives on addiction. J Am Psychoanal Assoc 47:791–815, 1999

Johnson B: Drug dreams: a neuropsychoanalytic hypothesis. J Am Psychoanal Assoc 49:75–96, 2001

Johnson C, Connors ME: The Etiology and Treatment of Bulimia Nervosa: A Biopsychosocial Perspective. New York, Basic Books, 1987

Johnson C, Tobin DL, Enright A: Prevalence and clinical characteristics of borderline patients in an eating-disordered population. J Clin Psychiatry 50:9–15, 1989

Kandel DB, Kessler RC, Margulies RZ: Antecedents of adolescent initiation into stages of drug use: a developmental analysis, in Longitudinal Research on Drug Use. Edited by Kandel DB. New York, Hemisphere, 1978, pp 73–78

Kaplan AS, Woodside DB: Biological aspects of anorexia nervosa and bulimia nervosa. J Consult Clin Psychol 55:645–653, 1987

Kaufman J, Yang B, Douglas-Palumberi H, et al: Genetic and environmental predictors of early alcohol use. Biol Psychiatry 61:1228–1234, 2007

Keel PK, Mitchell JE: Outcome in bulimia nervosa. Am J Psychiatry 154:313–321, 1997

Kendler KS, Heath AC, Neale MC, et al: A population-based twin study of alcoholism in women. JAMA 268:1877–1882, 1992

Kendler KS, Walters EE, Neale MC, et al: The structure of the genetic and environmental risk factors for six major psychiatric disorders in women: phobia, generalized anxiety disorder, panic disorder, bulimia, major depression, and alcoholism. Arch Gen Psychiatry 52:374–383, 1995

Kendler KS, Prescott CA, Myers J, et al: The structure of genetic and environmental risk factors for common psychiatric and substance use disorders in men and women. Arch Gen Psychiatry 60:929–937, 2003

Khantzian EJ: Psychopathology, psychodynamics, and alcoholism, in Encyclopedic Handbook of Alcoholism. Edited by Pattison EM, Kaufman E. New York, Gardner, 1982, pp 581–597

Khantzian EJ: Psychotherapeutic interventions with substance abusers: the clinical context. J Subst Abuse Treat 2:83–88, 1985a

Khantzian EJ: The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. Am J Psychiatry 142:1259–1264, 1985b

Khantzian EJ: A contemporary psychodynamic approach to drug abuse treatment. Am J Drug Alcohol Abuse 12:213–222, 1986

Khantzian EJ: The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. Harv Rev Psychiatry 4:231–244, 1997

Khantzian EJ, Treece C: DSM-III psychiatric diagnosis of narcotic addicts: recent findings. Arch Gen Psychiatry 42:1067–1071, 1985

Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971

Kohut H: How Does Analysis Cure? Edited by Goldberg A. Chicago, IL, University of Chicago Press, 1984

Lieb RC, Thompson TL II: Group psychotherapy of four anorexia nervosa inpatients. Int J Group Psychother 34:639–642, 1984

Liedtke R, Jäger B, Lempa W, et al: Therapy outcome of two treatment models for bulimia nervosa: preliminary results of a controlled study. Psychother Psychosom 56:56–63, 1991

Mack JE: Alcoholism, AA, and the governance of the self, in Dynamic Approaches to the Understanding and Treatment of Alcoholism. Edited by Bean MH, Zinberg NE. New York, Free Press, 1981, pp 128–162

Maher MS: Group therapy for anorexia nervosa, in Current Treatment of Anorexia Nervosa and Bulimia. Edited by Powers PS, Fernandez RC. Basel, Switzerland, S Karger, 1984, pp 265–276

Marcus MD, Wildes JE: Evidence-based psychological treatments for eating disorders, in Gabbard's Treatments of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

McCrady BS, Langenbucher JW: Alcohol treatment and healthcare system reform. Arch Gen Psychiatry 53:737–746, 1996

McIntosh VW, Jordan J, Carter FA, et al: Three psychotherapies for anorexia nervosa: randomized, controlled trial. Am J Psychiatry 162:741–747, 2005

McLellan AT, Arndt IO, Metzger DS, et al: The effects of psychosocial services in substance abuse treatment. JAMA 269:1953–1959, 1993

Mercer D, Woody GE: Individual psychotherapy and counseling for addiction, in The Oxford Textbook of Psychotherapy. Edited by Gabbard G, Beck J, Holmes J. Oxford, UK, Oxford University Press, 2005

Mintz IL: Self-destructive behavior in anorexia nervosa and bulimia, in Bulimia: Psychoanalytic Treatment and Theory. Edited by Schwartz HJ. Madison, CT, International Universities Press, 1988, pp 127–171

Minuchin S, Rosman BL, Baker L: Psychosomatic Families: Anorexia Nervosa in Context. Cambridge, MA, Harvard University Press, 1978

Mitchell JE, Pyle RL, Eckert ED, et al: A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa. Arch Gen Psychiatry 47:149–157, 1990

Mulder RT: Alcoholism and personality. Aust N Z J Psychiatry 36:44–52, 2002

Murphy GE, Wetzel RD: The lifetime risk of suicide in alcoholism. Arch Gen Psychiatry 47:383–392, 1990

Nathan PE: The addictive personality is the behavior of the addict. J Consult Clin Psychol 56:183–188, 1988

Nicholson B, Treece C: Object relations and differential treatment response to methadone maintenance. J Nerv Ment Dis 169:424–429, 1981

Oesterheld JR, McKenna MS, Gould NB: Group psychotherapy of bulimia: a critical review. Int J Group Psychother 37:163–184, 1987

Pages KP, Russo JE, Roy-Byrne PP, et al: Determinants of suicidal ideation: the role of substance use disorders. J Clin Psychiatry 58:510–515, 1997

Paton S, Kessler R, Kandel D: Depressive mood and adolescent illicit drug use: a longitudinal analysis. J Genet Psychol 131:267–289, 1977

Patton CJ: Fear of abandonment and binge eating: a subliminal psychodynamic activation investigation. J Nerv Ment Dis 180:484–490, 1992

Polivy J: Group psychotherapy as an adjunctive treatment for anorexia nervosa. J Psychiatr Treat Eval 3:279–283, 1981

Powers PS: Psychotherapy of anorexia nervosa, in Current Treatment of Anorexia Nervosa and Bulimia. Edited by Powers PS, Fernandez RC. Basel, Switzerland, S Karger, 1984, pp 18–47

Prescott CA, Kendler KS: Genetic and environmental contributions to alcohol abuse and dependence in a population-based sample of male twins. Am J Psychiatry 156:34–40, 1999

Project MATCH Research Group: Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. J Stud Alcohol 58:7–29, 1997

Reed PL, Anthony JC, Breslau N: Incidence of drug problems in young adults exposed to trauma and posttraumatic stress disorder: do early life experiences and predispositions matter? Arch Gen Psychiatry 64:1435–1442, 2007

Regier DA, Farmer ME, Rae BS, et al: Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. JAMA 264:2511–2518, 1990

Reich G, Cierpka M: Identity conflicts in bulimia nervosa: psychodynamic patterns and psychoanalytic treatment. Psychoanalytic Inquiry 18:383–402, 1998

Rhee SH, Hewitt JK, Young SE, et al: Genetic and environmental influences on substance initiation, use, and problem use in adolescents. Arch Gen Psychiatry 60: 1256–1264, 2003

Rounsaville BJ, Weissman MM, Kleber H, et al: Heterogeneity of psychiatric diagnosis in treated opiate addicts. Arch Gen Psychiatry 39:161–166, 1982

Rounsaville BJ, Anton SF, Carroll K, et al: Psychiatric diagnoses of treatment-seeking cocaine abusers. Arch Gen Psychiatry 48:43–51, 1991

Sandahl C, Herlitz K, Ahlin G, et al: Time-limited group psychotherapy for moderately alcohol dependent patients: a randomized controlled clinical trial. Psychotherapy Research 8:361–378, 1998

Schuckit MA: Genetics and the risk for alcoholism. JAMA 254:2614–2617, 1985

Selvini Palazzoli M: Self-Starvation: From Individual to Family Therapy in the Treatment of Anorexia Nervosa. Translated by Pomerans A. New York, Jason Aronson, 1978

Strober M, Humphrey LL: Familial contributions to the etiology and course of anorexia nervosa and bulimia. J Consult Clin Psychol 55:654–659, 1987

Sugarman A, Kurash C: The body as a transitional object in bulimia. Int J Eat Disord 1:57–67, 1982

Sullivan PF, Bulik CM, Fear JL, et al: Outcome of anorexia nervosa: a case-control study. Am J Psychiatry 155:939–946, 1998

Sutker PB, Allain AN: Issues in personality conceptualizations of addictive behaviors. J Consult Clin Psychol 56:172–182, 1988

Tasca GA, Ritchie K, Conrad G, et al: Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: an aptitude by treatment interaction. Psychother Res 16:106–121, 2006

Thompson-Brenner H, Glass S, Westen D: A multidimensional meta-analysis of psychotherapy for bulimia nervosa. J Clin Psychol 10:269–287, 2003

Treece C: Assessment of ego functioning in studies of narcotic addiction, in The Broad Scope of Ego Function Assessment. Edited by Bellak L, Goldsmith LA. New York, Wiley, 1984, pp 268–290

Treece C, Khantzian EJ: Psychodynamic factors in the development of drug dependence. Psychiatr Clin North Am 9:399–412, 1986

Vaillant GE: Dangers of psychotherapy in the treatment of alcoholism, in Dynamic Approaches to the Understanding and Treatment of Alcoholism. Edited by Bean MH, Zinberg NE. New York, Free Press, 1981, pp 36–54

Vaillant GE: The Natural History of Alcoholism. Cambridge, MA, Harvard University Press, 1983

Vaillant GE: The alcohol-dependent and drug-dependent person, in The New Harvard Guide to Psychiatry. Edited by Nicholi AM Jr. Cambridge, MA, Belknap Press of Harvard University Press, 1988, pp 700–713

Vitousek KM, Gray JA: Psychotherapy of eating disorders, in Oxford Textbook of Psychotherapy. Edited by Gabbard G, Beck J, Holmes JA. Oxford, UK, Oxford University Press, 2005

von Ranson KM, Wallace LM, Stevenson A: Psychotherapies provided for eating disorders by community clinicians: infrequent use of evidence-based treatment. J Psychother Res 23:333–343, 2013

Walsh Z, Allen CA, Kosson DS: Beyond social deviance: substance use disorders and the dimensions of psychopathy. J Pers Disord 21:273–288, 2007

Westen D, Harnden-Fischer J: Personality profiles in eating disorders: rethinking the distinction between Axis I and Axis II. Am J Psychiatry 158:547–562, 2001

Williams G: Reflections on some dynamics of eating disorders: "no entry" defenses and foreign bodies. Int J Psychoanal 78:927–941, 1997

Wilson CP (ed): Fear of Being Fat: The Treatment of Anorexia Nervosa and Bulimia. New York, Jason Aronson, 1983

Woody GE: Individual therapy for substance use disorders, in Gabbard's Treatments of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Woody GE, Luborsky L, McLellan AT, et al: Psychotherapy for opiate addicts: does it help? Arch Gen Psychiatry 40:639–645, 1983

Woody GE, McLellan AT, Luborsky L, et al: Severity of psychiatric symptoms as a predictor of benefits from psychotherapy: the Veterans Administration–Penn Study. Am J Psychiatry 141:1172–1177, 1984

Woody GE, McLellan AT, Luborsky L, et al: Sociopathy and psychotherapy outcome. Arch Gen Psychiatry 42:1081–1086, 1985

Woody GE, McLellan AT, Luborsky L, et al: Psychotherapy for substance abuse. Psychiatr Clin North Am 9:547–562, 1986

Woody GE, McLellan AT, Luborsky L, et al: Twelve-month follow-up of psychotherapy for opiate dependence. Am J Psychiatry 144:590–596, 1987

Woody GE, McLellan AT, Luborsky L, et al: Psychotherapy in community methadone programs: a validation study. Am J Psychiatry 152:1302–1308, 1995

Woody GE, Gallop R, Luborsky L, et al: HIV risk reduction in the National Institute on Drug Abuse Cocaine Collaborative Treatment Study. J Acquir Immune Defic Syndr 33:82–87, 2003

Wurmser L: Psychoanalytic considerations of the etiology of compulsive drug use. J Am Psychoanal Assoc 22:820–843, 1974

Wurmser L: Flight from conscience: experience with the psychoanalytic treatment of compulsive drug abusers, I: dynamic sequences, compulsive drug use. J Subst Abuse Treat 4:157–168, 1987a

Wurmser L: Flight from conscience: experience with the psychoanalytic treatment of compulsive drug abusers, II: dynamic and therapeutic conclusions from the experiences with psychoanalysis of drug users. J Subst Abuse Treat 4:169–179, 1987b

Yager J: The treatment of bulimia: an overview, in Current Treatment of Anorexia Nervosa and Bulimia. Edited by Powers PS, Fernandez RC. Basel, Switzerland, S Karger, 1984, pp 63–91

Zipfel S, Wild B, Groß G, et al: Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial. Lancet Oct 11, 2013 doi:10.1016/S0140-6736(13)61746-8 [Epub ahead of print]

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CHAPTER 13

NEURODEVELOPMENTAL AND NEUROCOGNITIVE DISORDERS

> It is faulty in principle to try to make a distinction between so-called organic and functional diseases, as far as symptomatology and therapy are concerned. In both conditions, one is dealing with abnormal functioning of the same psychophysical apparatus and with the attempts of the organism to come to terms with that. If the disturbances—whether they are due to damage to the brain or to psychological conflicts—do not disappear spontaneously or cannot be eliminated by therapy, the organism has to make a new adjustment to life in spite of them. Our task is to help the patients in this adjustment by physical and psychological means; the procedure and goal of the therapy in both conditions is, in principle, the same.
>
> *Kurt Goldstein*

In this classic cautionary statement against mind/brain dualism, Goldstein reminds us of the fundamental interdependence of psychology and biology. The traditional distinction between organic and functional syndromes im-

plies that psychology is irrelevant to the former and biology irrelevant to the latter. Because the term *organic* generally denotes the presence of actual anatomic damage to neuronal and glial structures, some psychiatrists view such disorders as outside their purview and therefore refer patients with them to neurologists. Dynamic psychiatrists in particular may view patients with structural brain damage as so lacking in the capacity for abstraction that they are inaccessible to psychotherapeutic intervention. This abdication is unfortunate because dynamic clinicians have much to contribute to the cognitively impaired patient.

I divide the considerations of diagnostic understanding and treatment into developmental conditions and those that occur late in life related to cognitive deterioration. I follow the DSM-5 designations of neurodevelopmental disorders, on the one hand, and neurocognitive disorders, on the other (American Psychiatric Association 2013). In this regard I am not attempting to be comprehensive. My goal is more modest, that is, to provide examples of conditions in which the interface of psychodynamic thinking and brain dysfunction can be examined and elaborated. I use the conditions at the higher end of the autistic spectrum disorder as examples of neurodevelopmental disorders and dementias as examples of neurocognitive disorders.

Neurodevelopmental Disorders

The DSM-5 category of autistic spectrum disorder (ASD) is an example of introducing the dimensional model into the official nomenclature, implicitly rejecting an all-or-nothing approach to diagnosis. In this sweeping change, both pervasive developmental disorder not otherwise specified and Asperger's disorder disappeared from the diagnostic system. This discussion will focus on the mild end of the autism spectrum, which was formerly referred to as Asperger's disorder. However, a problem with this distinction is identifying the boundary between social behaviors that are peculiar or eccentric on the one hand and true autism spectrum disorders on the other. A subjective component inevitably comes into play in making that distinction, and clinicians vary in their tolerance for unusual and eccentric behavior in the consulting room. Tanguay (2011) argues that the core difficulty for individuals in this spectrum is a failure of social communication development. The higher levels of ASD, specifically what traditionally has been known as Asperger's syndrome, is generally regarded as differing from the more severe disorders in the spectrum by the relative preservation of cognitive and linguistic development.

Some of the most compelling discussions of the autism spectrum disorder have come from those who have conditions on that spectrum them-

selves. Temple Grandin, for example, makes the point that some persons who are suffering from variations of what used to be called Asperger's may be able to communicate nonverbally even if their social communication at a verbal level is clearly impaired (Grandin and Panek 2013). She stresses that genetic studies suggest that there are highly diverse DNA changes in this spectrum and no clear coherent etiology. She strongly argues for considering each case individually and recognizing that placing each person in an environment that is optimal is crucial for the treatment of people with ASD.

The development of the self depends on an intersubjective matrix beginning with the one between mother or caregiver and the child (D.N. Stern 2004). Children with structurally based impairment in communication and cognition are unable to perceive accurately or integrate effectively the emotional signals from the mother. The discussion of mentalization in Chapter 2 may be highly relevant to working with patients with ASD. A central problem with those who reside on the spectrum is a difficulty in understanding their own mind and the mind of others (Cohler and Weiner 2011). Patients with ASD may be unable to use mentalizing as a means of self-protection from experiences that are overwhelming and confusing. Other persons are enigmatic, as their intentions cannot be understood or predicted by patients with ASD. A more predictable world of schedules, dates, anniversaries, physical laws, and numbers may be more reliable than inner personal relationships.

The history of efforts to apply psychoanalytic or psychodynamic thinking to autism has been one of the disgraces of the field of psychiatry. Mothers were often blamed for the illness and were referred to as *refrigerator mothers*. Many of the mother-blaming contributions fail to take into account how parents were reacting to a highly complex child who was different from what they expected. As a reaction to misguided treatments, some therapists have felt that long-term psychodynamic therapy has no place in the treatment of patients who have diagnoses that place them on the higher end of the ASD spectrum. However, in recent years the situation has changed as more and more sophisticated arguments have been made for the value of psychodynamically informed therapies for these patients (Cohler and Weiner 2011; Polemear 2004; Sugarman 2011; Volkmar 2011). Some modifications may be necessary to provide a holding environment and to encourage self-examination (Polemear 2004), but these individuals are not out of reach of human connectedness. Patients on this spectrum may have idiosyncratic interests and preoccupations, but these phenomena still have meaning for the patient. Meanings are at the core of dynamic therapy. Cohler and Weiner (2011) pointed out that "the therapist's very act of trying to understand the patient within the context of the two-person relationship of psychotherapy becomes a way of modeling how one goes about getting to know another in a safe environment where the patient does not feel overwhelmed" (p. 219).

Using the model of mentalizing shifts the therapist approach away from the more classical psychoanalytic task of understanding repressed and warded-off unconscious conflicts. Sugarman (2011) defined the form of insightfulness that one is striving to attain with ASD patients as the equivalent of mentalizing. By judicious use of self-disclosure, one can help high-functioning ASD patients begin to learn how another person's mind reacts to the patient's comments and behavior. The goal of the treatment is to help the patient learn to observe his or her own mind and action, including the tendency to disrupt certain functions defensively in interpersonal settings. Research on patients with what was formerly called Asperger's syndrome (Senju et al. 2009) showed that although such individuals cannot grasp mental states in others implicitly or automatically, they may be able to learn explicit mentalizing skills through concerted effort and help from others.

Sugarman (2011) also stressed that character defenses inevitably develop as a person on the ASD spectrum reacts to the difficulty in understanding human interactions. He noted that interventions involving psychodynamic conflict are not particularly useful. On the other hand, his patient's experience of having his idealized view of himself shattered by the realistic limits of his capacity to accomplish his goals proved to be a fruitful subject of discussion in the therapy. After 2 years of therapy, Sugarman's patient began to be able to reflect on his own narcissistic vulnerability. Narcissistic defenses may be necessary to cope with the overwhelming nature of the world when one is not equipped to mentalize how others are thinking, feeling, and reacting. Sugarman stresses that treatment is psychodynamic or psychoanalytic because one is ultimately helping the patient to be self-reflective and to understand an internal world that has been hidden from view through the use of massive defenses.

A flexible approach that provides ego support and empathy must be the cornerstone of treatment when one is working with higher-level ASD patients. Moreover, the countertransference challenges may be formidable. One often feels as though one is peripheral to the patient and can experience isolation and alienation in the consulting realm. One must find a way to engage in a dialogue at the patient's developmental level and overcome one's own narcissistic need to be validated, listened to, and valued. If one persists, meaningful dialogue can emerge that builds a bridge to the patient so the isolation is less for both parties. Encouraging mentalizing is illustrated in the example below.

> Mr. X was a 20-year-old man who was in his third year of college when he came to psychotherapy. He told his psychiatrist that he knew he was depressed. He had been told by others that he was "Asperger-like." He had read up on Asperger's syndrome on the Internet and also in a popular book. He

told his psychiatrist that he thought he also had depression, citing a reference that 10%–15% percent of people with Asperger's syndrome have clinical depression at some point.

His psychiatrist observed to Mr. X that he had done well in college and currently had a 3.8 grade point average. He wondered what was making Mr. X depressed. Mr. X said that the girl who sat next to him in one of his college classes paid no attention to him, and he felt rather hopeless about getting her attention. He then launched into a detailed discussion of his recent review of the literature on treatment of depression. He said that there was a consensus that electroconvulsive therapy (ECT) was the most successful treatment of severe depression. He asked his psychiatrist if he could be administered that treatment. The psychiatrist explained that usually ECT was reserved for more severe cases that did not respond to the antidepressant medications or psychotherapy. He asked Mr. X if he would consider trying psychotherapy and medication first. Mr. X was adamant that he wanted to have ECT as soon as possible. At the next session, Mr. X began by asking the psychiatrist if he remembered his request for ECT. His doctor responded that he remembered it but wanted to explore the reasons for Mr. X's demands a little bit further. Mr. X was silent at first, and then, looking at the floor, he said with considerable shame, "I want to forget something." The psychiatrist asked him to elaborate. Mr. X responded that he had asked the girl sitting next to him in class if she thought he was good-looking. He said she looked away and did not answer the question.

Mr. X was devastated by the girl's response and found that it was very difficult to sleep at night because he went over and over the exchange with the girl to the point that it kept him awake until the wee hours of the morning. He had read that ECT often caused memory loss. He said the reason for his preference for ECT was a wish to permanently eradicate the memory of his experience of being rejected by a girl he desired. This breakthrough in the psychotherapy gave his psychiatrist a chance to explore themes of shame, humiliation, and self-expectation that haunted Mr. X. It also opened up an area of great importance to the future of Mr. X's interpersonal relationships, that is, his interpersonal style with others in his class and the nonverbal signals he gave out. This aspect was dealt with both within the transference and in his outside relationships. To promote mentalizing, the psychiatrist asked him, "When the girl did not answer your question, what did you suppose she was thinking?" Mr. X did not know, so his psychiatrist invited him to think of the various possibilities. Eventually, Mr. X realized that asking that question out of the blue "must have freaked her out." This realization led to a useful discussion about making small talk as a way of building a relationship. Mr. X said, "I'm not good at small talk." His psychiatrist replied, "Exactly. It helps if you can try hard to think about what the other person is thinking."

Neurocognitive Disorders

The self, at the most fundamental level, is a product of brain functioning. Damage to brain tissue may produce significant alterations in an individual's

sense of identity, thus causing family and loved ones to feel that the patient is no longer the same person. Brain trauma typically affects the frontal and temporal lobes, dramatically influencing the patient's ability to interpret the meaning of stimuli and to connect them with relevant feelings (Prigatano 1989). Such alterations strike at the very heart of the personality.

The awareness of the self is difficult to localize to one area of the brain. Studies of patients whose cerebral hemispheres have been surgically disconnected (Sperry et al. 1979) suggest that the sense of self is present in both halves of the brain. It appears to be a complex schema to which different brain regions make different contributions.

Patients react to their loss of identity in certain characteristic ways. Goldstein (1952), one of the first investigators of the psychological effects of brain damage, described an anxiety state that he termed the *catastrophic condition* or *reaction*. When brain-injured patients were asked to perform a simple task that had been no problem for them prior to the trauma, they became angry, agitated, and extremely anxious. Goldstein observed that they perceived their failure to complete the task as a danger to their very existence. As a reaction to this threat, patients characteristically restrict their lives so that they are not exposed to unfamiliar situations or impossible tasks. Thus they defend against catastrophic anxiety by avoiding awareness of their defects. These patients commonly become excessively orderly to the point of being obsessive-compulsive. Keeping everything in place gives them the illusion of control over their environment. It also transforms passivity into activity and provides a concrete solution to a complex, abstract problem.

When brain-injured patients can restrict their lives sufficiently, they may appear remarkably free of anxiety and oblivious to their deficits. Despite showing evidence of memory problems, childish behavior, and a short temper, they often may deny any limitations. In fact, one study (Oddy et al. 1985) found that 40% of patients studied 7 years after an insult to the brain disavowed any disability whatsoever. Clinicians may struggle to differentiate between neurogenic and psychogenic denial in such patients. Lewis (1991) has pointed out that, in contrast to psychological forms of denial, neurogenic denial remits within hours or days of the injury, appears as a pattern of overall deficits rather than as an isolated symptom, and does not produce anxiety or agitation in patients who are confronted with it.

The gradual loss of functioning typical of dementia syndromes generally presents a somewhat different picture. People with dementia preserve a sense of who they are until relatively late in the course of the illness. They may be able to perform their usual work and conduct their usual social routines reasonably well. About two-thirds of all dementia cases involve Alzheimer's disease, and the average duration of the decline in such cases is about 10 years (Small et al. 1997). During this period of decline, which may last as long as 20

years, a variety of mood and personality disturbances may emerge in addition to the cognitive decline. As the illness progresses, the patient is likely to experience increasing difficulty with calculation, performance of complex tasks, and fluency of language. At this point in the illness, when patients realize that they cannot perform the tasks they were once able to, catastrophic reactions may emerge that are similar to those in brain-injured patients. Similarly, eruptions of anger and even combativeness may develop as the disease progresses.

From a psychodynamic perspective, the loss of mental faculties associated with progressive dementia can be understood as a regressive process in the ego, in which more mature defense mechanisms give way to more primitive modes of defense (Weiner 1991). Aspects of the personality that have been partially suppressed by a biologically intact cortex gradually emerge as defensive layers are eroded. High-level defenses such as altruism are replaced by self-absorption, for example. Denial and projection are perhaps the two most common primitive defenses used by persons with dementia. When a memory failure occurs, patients with dementia blame others rather than acknowledge responsibility for the error themselves.

In many aging patients with dementia of the Alzheimer's type, the tragedy of the illness is that self-awareness may remain intact as a number of the mental faculties deteriorate. Because recent memory tends to be sacrificed before remote memory, many patients can clearly recollect how they used to be, which makes their current dysfunctional state all the more disturbing to them. To a large extent, the continuity of the self over time depends on the capacity of memory. When remote memories begin to fade as the illness progresses, then the patient's identity begins to disappear along with the memories. Ultimately, the patient cannot recognize loved ones and family members and can no longer remember significant life events.

The value of dynamic psychotherapy for dementia patients has been noted by several authors (Lewis 1986; Lewis and Langer 1994; Lewis and Rosenberg 1990; J. M. Stern 1985). A major goal of any psychotherapeutic process with these patients is to help them accept the extent of their deficits and their limitations in terms of returning to work. To accomplish this goal, the therapist must be sensitive to the narcissistic injury inherent in accepting the irreparable damage to one's skills, intellectual capabilities, talents, and even the very essence of one's personality. It is essential for the therapist to respect and empathize with the patient's need to use denial (Lewis 1991). Blunt confrontations of denial are likely to accomplish nothing and may even destroy any hope of developing a therapeutic alliance. Promoting self-acceptance of these cognitive limitations requires therapists to gradually expose their patients to the reality of the deficits in a way that allows the patients to briefly mourn week by week, over an extended period. Symbolization may assist in the mourning process (Lewis and Langer 1994).

Many clinicians are guardedly optimistic about the treatment of brain-injured patients. Progressive dementia, on the other hand, often elicits profound pessimism in treaters. When treatable causes of dementia (e.g., depression, hypothyroidism, vitamin deficiencies, porphyria, neoplasm, and encephalitides) are ruled out, some clinicians reluctantly diagnose Alzheimer's disease and withdraw from a therapeutic role. This unfortunate withdrawal is associated with the view that Alzheimer's disease is untreatable. From a psychodynamic perspective, however, there is no such thing as an untreatable dementia. Much can be done to help these patients and their families deal with Alzheimer's on a daily basis.

An individual or family therapist must be alert to the risk of depression in the early stages of a patient's descent into Alzheimer's disease. Zabenko et al. (2003) identified a high frequency of major depression at or after the onset of cognitive impairment in patients who had no history of premorbid depressive episodes. Their research indicated a prevalence of major depression in the range of 22.5% to 54.4% across sites. They suggested that this major depression syndrome of Alzheimer's disease may be among the most common mood disorders of older adults. A psychodynamic therapist may also help the patient deal with the anxiety associated with an impending loss of the self, which may verge on existential terror (Garner 2003). Because memory is critically important to a sense of continuity of the self, psychotherapists may wish to encourage patients with dementia to tell and retell individual life stories. As the disease progresses, the therapist may then serve in an auxiliary ego function by helping the patient recall significant memories and the overall life narrative (Hausman 1992). This process also helps the patient feel less isolated. Elderly patients often have a terror of having an unobserved life. When the therapist listens to the life stories and serves as a witness to what has transpired in the patient's life, these moments may have extraordinary therapeutic value for the patient (Gabbard 2010; Poland 2000). Some patients will feel a renewed sense of meaning and purpose and even a sense that they have not lived in vain. Butler (1963) referred to this therapeutic model as "life review," and in some cases, these reminiscences may lead to memories of joy and purpose as well as instances of sadness and loss. These memories may help them work through the sense of loss they face. Patients in the early stages of dementia worry about losing a sense of self. After all, in essence, the sense of self is memory. Chaudhury (2008) emphasizes that those who work with patients with dementia must be attuned to the changing subjective sense of self. Reminiscing about the patient's life is helpful, but he also stressed the importance of "home," whether the true home of childhood or the current place where one lives as a way of anchoring the self. Moreover, these patients also become extremely worried about losing connection with others. This concern may take the form of losing the

physical presence of others, but it also may present as a fear of losing the capacity to retain others as mental representations. Internal objects, particularly soothing introjects, may be sacrificed as part of the dementia process.

> Mr. Y was an 81-year-old married man in the early stages of Alzheimer's dementia. He was beginning to have trouble remembering his 49-year-old daughter and her children. Although she visited him every week and was supportive and loving, he had trouble remembering what she looked like between visits. He came to his therapist's office for a morning session one day and said that he had just awakened from a dream prior to coming to therapy. He said he could not get the dream out of his mind. When the therapist asked Mr. Y to describe the details of the dream, Mr. Y said that he encountered his daughter and her two children on the street, but he could not quite see their faces. He said that no matter how hard he strained to identify their facial features, they seemed to be fading away so he could not recognize them. When he woke up, he looked at a photograph of his daughter and grandchildren that was next to his bed. Mr. Y's therapist asked if he were afraid of not being able to retain an image of them in his mind. Mr. Y responded tearfully, "I worry that when they come to visit I won't remember what they look like, and I won't know who they are."

Mr. Y's fear reflects how the loss of internal representations of others may be just as threatening as loss of supportive caregivers in the immediate external environment. Indeed, feelings of loneliness should be a major focus of psychotherapeutic efforts in people in the early stages of dementia and even elderly people who are not yet showing signs of dementia. In a study of 2,173 nondemented elderly persons who were followed for 3 years (Holwerda et al. 2012), feeling lonely rather than being alone was associated with an increased risk of clinical dementia. The investigators suggested that feelings of loneliness should be considered a major risk factor and that such feelings may signal the prodromal stage of dementia. Researchers also found that people who lived alone or who were no longer married were between 70% and 80% more likely to develop dementia than those who lived with others or who were married. Hence, the nature of both external relationships and an internal sense of being impoverished of relationships should be therapeutic targets for individual psychotherapists.

Psychotherapists may also wish to focus on "purpose in life" in their efforts with patients who appear to be in the early stages of dementia or who show some indication of cognitive struggles. Purpose in life is usually defined as the psychological tendency to derive meaning from life's experiences and possess a sense of intentionality and goal directedness (Boyle et al. 2012). Studies have shown that purpose in life is generally associated with psychological and cognitive health in elderly persons (Hedberg et al. 2010). A more recent investigation of 246 community-based older persons

(Boyle et al. 2012) found that higher levels of purpose in life reduced the deleterious effects of Alzheimer's disease pathological changes on cognition in the advanced aged. Although there was some assumption of that connection, postmortem examinations of the subjects in the study made it clear that there is a measurable effect of purpose in life on the pathological changes connected with cognitive decline.

Special modifications of therapy are often useful with patients in the early stages of Alzheimer's. Shorter but more frequent sessions are often helpful (Garner 2003). Using photographs as reminders to assist in life-review techniques can also be useful. Getting to and from the office may become so difficult that a visit to the retirement center or to the patient's home may be necessary.

Consultation and supervision may be necessary when attempting to treat this population. Many therapists will feel overwhelmed by the deterioration and impending death of their patients. They will be imbued with a sense of helplessness and impotence (Garner 2003). They also may find the patient's affective lability hard to take at times. Some patients will flood the session with tears in a seemingly inconsolable grief. Most troubling of all, therapists may experience aggressive feelings because of a sense of irritation at the lack of progress and the fact that they have to repeat everything over and over again because of the patient's forgetting. As a result of their irritation, they may engage in excessive self-reproach and guilt over their failure to be a supportive and caring therapist.

Some patients in the early stages of Alzheimer's dementia may use denial to prevent the full impact of the illness from entering conscious awareness. Clinicians treating such patients must respect their need for denial but also help them tie up loose ends with business and family before it is too late (Martin 1989). Hence an ongoing issue for every therapist is to attend to practical and legal matters based in reality while also trying to improve the patient's level of suffering.

Psychotherapy is often not seen as a helpful modality by Alzheimer's patients or their families. Clinicians may need to initiate the psychotherapeutic process rather than waiting for a request from the patient. The stories that these patients tell may be rich in metaphorical allusions that are therapeutically useful (Cheston 1998). A crucial aspect of a psychodynamic approach to dementia is to recognize that these patients can be reached emotionally long after they have experienced major cognitive losses. Fifty-one people with a probable diagnosis of Alzheimer's disease were studied in the aftermath of the Kobe earthquake in 1995 (Ikeda et al. 1998). Their memories of the earthquake, measured at 6 and 10 weeks afterward, were compared with their memories of undergoing a magnetic resonance imaging scan immediately following the earthquake. Whereas only 31% of the subjects remembered the

scan, fully 86% remembered the earthquake, including subjects with severe dementia. One of the implications of these findings is that patients with dementia can be engaged around emotionally meaningful events in their lives. In an editorial accompanying this landmark study, Williams and Garner (1998) emphasized that "these people have islands of memory, which, if discovered and utilized, can have an activating effect and release further memories" (p. 379). The authors also advocated the introduction of meaningful stimulation into the daily activity pattern of patients with dementia to help decrease the rate of memory loss and maintain an affective connection to treaters.

Another key principle in psychodynamically informed treatment is to do what one can to preserve the self-esteem of the patient who is slipping cognitively and reinforce adaptive defenses.

The following case example illustrates some useful principles of management:

> Mr. Z was a 59-year-old Protestant minister with a 4-year history of deterioration in his mental functioning. Members of his congregation had noticed a sense of apathy about him and a sloppiness in his administrative functioning. Church bulletins were poorly organized, and he seemed to be less conscientious about carrying out his commitments to various parishioners. Mr. Z's wife noticed that he often failed to fulfill simple requests. She would become angry at him for "selective hearing" when he indicated to her that he had forgotten what she said.
>
> Mrs. Z brought her husband for psychiatric evaluation, complaining that he was "just not the same." Mr. Z conceded that he felt as though something were happening to him, but he was unable to be more specific than to say that he could not remember as well as he used to. Mrs. Z complained that their marital relationship was deteriorating because her husband did not attend to her needs as he had in the past. Mr. Z expressed hurt at the feedback from members of his congregation, and he noted that he was starting to feel like a failure.
>
> Mental status examination revealed problems with short-term memory and calculation and minor difficulties with orientation to time. Mr. Z also showed signs of mental inertia, as he was unable to move from one subject to another or from one task to another unless given considerable time. Extensive diagnostic studies ruled out causes of dementia stemming from trauma, infection, neoplasm, and normal-pressure hydrocephalus or from autoimmune, metabolic, hematologic, vascular, and toxic factors. Also negative were findings from a computed tomography scan, skull X rays, and electroencephalogram. Neuropsychological testing was more productive, with the following results noted: 1) mild-to-moderate deficits in manual dexterity, 2) mild-to-moderate deficits in perceptual functioning, 3) mild-to-moderate deficits in recent memory, 4) diffuse organic dysfunction typical of progressive neurological disease, and 5) a decrease in attention span.
>
> After the diagnosis of dementia of unknown origin was determined (Alzheimer's in a 59-year-old man is unusual but not unheard of), the diagnostic

findings were explained to the patient and his wife. When Mrs. Z could accept her husband's structural brain damage, she was able to lower her expectations for his responses to her. Instead of assuming that he would always react to her verbal comments as he had in the past, she tried new ways of relating to him. At the psychiatrist's suggestion, she slowed her rate of speech and repeated comments that did not seem to register. She also tried rewording comments that Mr. Z did not seem to understand. Above all, she no longer was so easily irritated with him, leading to more positive interactions between the two of them and a corresponding increase in Mr. Z's self-esteem.

Mr. Z had always been an orderly, fastidious person with prominent obsessive-compulsive character traits. To deal with his sense that his intellectual and administrative capacities were deteriorating, he had begun to read the Bible 2 or 3 hours a day, both to encourage divine intervention and to attempt to gain mastery over the information he hoped to impart to his congregation. The evaluating psychiatrist helped Mr. Z marshal his obsessive-compulsive character traits more effectively. As a result, Mr. Z began to sit down with his wife each morning to write out a daily schedule of what he had to do between breakfast and bedtime. Moreover, he began to carry a notebook at all times so he could write down what other people told him and thereby remember what he had to do.

Mr. Z's self-esteem had depended on his role as minister, and his inability to continue in that capacity inflicted a deep narcissistic wound. Initially, he protested when the psychiatrist advised him to reduce his responsibilities. However, with Mr. Z's permission, his associate minister was enlisted as an ally in devising ways for Mr. Z to continue to serve the church without being placed in situations in which he was faced with impossible tasks. For example, the associate minister began to prepare and type the weekly bulletin, but Mr. Z continued to operate the printer to produce the required number for the Sunday service. Thus Mr. Z continued to feel productive, which helped him preserve some degree of self-esteem. By avoiding tasks that were beyond his capabilities, he also avoided repeated narcissistic injuries.

The case of Mr. Z illustrates several useful principles in the dynamically informed management of dementia: 1) attend to self-esteem issues; 2) assess characteristic defense mechanisms and help the patient use them constructively; 3) find ways to replace defective ego functions and cognitive limitations, such as keeping calendars for orientation problems, taking notes for memory problems, and making schedules for problems of secondary autonomous functioning; and 4) assist family members in developing new ways of relatedness that shore up the patient's self-esteem by decreasing negative interactions.

Ultimately, the patient's family members are the main focus of intervention as they struggle with anger, guilt, grief, and exhaustion in the face of the patient's inexorable decline. In fact, some regard family therapy as the dynamic treatment of choice in Alzheimer's dementia (Lansky 1984). Blaming of self and others is a frequent development in family members. Also, the re-

adjustment of family roles may require intervention. Clinicians can help families with practical recommendations about such things as low lighting levels, the use of music to enhance the environment, the issuing of commands at the patient's comprehension level, and other psychoeducational efforts. Simple measures like covering a doorknob may prevent the patient from feeling like he must open the door and walk out of his apartment. They can also be referred to resources such as those developed by the American Academy of Neurology (Doody et al. 2001) and local Alzheimer's support groups. In a randomized controlled study (Mittelman et al. 2004) of 406 spouse caregivers of Alzheimer's disease patients living at home, caregivers who received six sessions of individual and family counseling and who agreed to join support groups had significantly fewer depressive symptoms after the intervention than did control subjects. These effects were sustained for 3.1 years after baseline, as well as after nursing home placement or death of the patient. A subsequent report from the same research group showed that the spouses who were caring for partners reported better physical health if they participated in individual or group counseling (Mittelman et al. 2007). The effect on health began 4 months after beginning the intervention and lasted more than a year.

Clinicians can also help caregivers by explaining to them what not to do. For example, when a patient with Alzheimer's disease blames a caregiver for stealing something that he or she cannot find, it does little good to challenge such beliefs (Weiner and Teri 2003). Instead, the caregiver can simply help the patient look for what has been lost. If a stimulus in the environment leads the patient to become angry or irritable, the caregiver should probably remove the stimulus rather than try to reason with the patient. In general, nonconfrontation is the best strategy. Caregivers should also be helped to provide a structured routine that is consistently reinforced, even if it may take considerable effort to do so. When patients know that they get out of bed at a certain time, take their meals at another time, and go for a walk after a meal, for example, they have a predictable environment to navigate. This can greatly reduce anxiety based on uncertainty and unpredictability.

The final task, of course, involves the acceptance of death. Clinicians who struggle along with these families in such situations will often find the treatment process a trying one, but they can pride themselves on having made a significant impact on the lives of all involved. In the end, when clinicians are consoling the family and loved ones who have lost a valuable person in their lives, they can empathize with the time-honored notion that in Alzheimer's disease, the tragedy is not the death but the disease itself.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Boyle PA, Buchman AS, Wilson RS, et al: Effect of purpose in life in the relation between Alzheimers disease pathologic changes on cognitive function in advanced age. Arch Gen Psychiatry 69:499–506, 2012

Butler RN: The life review: an interpretation of reminiscence in the aged. Psychiatry 26:65–76, 1963

Chaudhury H: Remembering Home: Rediscovering the Self in Dementia. Baltimore, MD, Johns Hopkins University Press, 2008

Cheston R: Psychotherapeutic work with people with dementia: a review of the literature. Br J Med Psychol 71:211–231, 1998

Cohler BJ, Weiner T: The inner fortress: symptom and meaning in Asperger's syndrome. Psychoanalytic Inquiry 31:208–221, 2011

Doody RS, Stevens JC, Beck C, et al: Practice perimeter: management of dementia (an evidence-based review). Neurology 56:1154–1166, 2001

Gabbard GO: Long-Term Psychodynamic Psychotherapy: A Basic Text, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2010

Garner J: Psychotherapies and older adults. Aust N Z J Psychiatry 37:537–548, 2003

Goldstein K: The effect of brain damage on the personality. Psychiatry 15:245–260, 1952

Grandin T, Panek R: The Autistic Brain: Thinking Across the Spectrum. New York, Houghton Mifflin Harcourt, 2013

Hausman C: Dynamic psychotherapy with elderly demented patients, in Care-Giving in Dementia. Edited by Jones GMM, Miesen BML. London, Tavistock/Routledge, 1992, pp 181–198

Hedberg P, Gustafson Y, Brulin C: Purpose in life among men and women age 85 years and older. Int J Aging Hum Dev 70:213–229, 2010

Holwerda TJ, Deegd JA, Beekman ATF, et al: Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL). J Neurol Neurosurg Psychiatry Dec 10, 2012 [Epub ahead of print] doi:10.1136/jnnp-2012-302755

Ikeda M, Mori E, Hirono N, et al: Amnestic people with Alzheimer's disease who remembered the Kobe earthquake. Br J Psychiatry 172:425–428, 1998

Lansky MR: Family psychotherapy of the patient with chronic organic brain syndrome. Psychiatr Ann 14:121–129, 1984

Lewis L: Individual psychotherapy with patients having combined psychological and neurological disorders. Bull Menninger Clin 50:75–87, 1986

Lewis L: The role of psychological factors in disordered awareness, in Awareness of Deficit After Brain Injury: Clinical and Theoretical Issues. Edited by Prigatano GP, Schachter DL. New York, Oxford University Press, 1991, pp 223–239

Lewis L, Langer KG: Symbolization in psychotherapy with patients who are disabled. Am J Psychother 48:231–239, 1994

Lewis L, Rosenberg SJ: Psychoanalytic psychotherapy with brain-injured adult psychiatric patients. J Nerv Ment Dis 17:69–77, 1990

Martin RL: Update on dementia of the Alzheimer type. Hosp Community Psychiatry 40:593–604, 1989

Mittelman MS, Roth DL, Coon DW, et al: Sustained benefit of supportive intervention for depressive symptoms in caregivers of patients with Alzheimer's disease. Am J Psychiatry 161:850–856, 2004

Mittelman MS, Roth DL, Clay OJ, et al: Preserving health of Alzheimer caregivers: impact of the spouse caregiver intervention. Am J Geriatr Psychiatry 15:780–789, 2007

Oddy M, Coughlan T, Tyreman A: Social adjustment after closed head injury: a further follow-up seven years after injury. J Neurol Neurosurg Psychiatry 48:564–568, 1985

Poland WS: The analyst's witnessing and otherness. J Am Psychoanal Assoc 48:17–35, 2000

Polemear C: Finding the bridge: psychoanalytic work with Asperger's syndrome adults, in The Many Faces of Asperger Syndrome. Edited by Rhode M, Klauber T. London, Karnac Books, 2004, pp 86–107

Prigatano GP: Work, love, and play after brain injury. Bull Menninger Clin 53:414–431, 1989

Senju A, Southgate V, White S, et al: Mindblind eyes: an absence of spontaneous theory of mind in Asperger syndrome. Science 325:883–885, 2009

Small GW, Rabins PV, Barry PB, et al: Diagnosis and treatment of Alzheimer's disease and related disorders: consensus statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatric Society. JAMA 278:1363–1371, 1997

Sperry RW, Zaidel E, Zaidel D: Self-recognition and social awareness in the deconnected minor hemispheres. Neuropsychologia 17:153–166, 1979

Stern DN: The Present Moment in Psychotherapy and Everyday Life. New York, WW Norton, 2004

Stern JM: The psychotherapeutic process with brain-injured patients: a dynamic approach. Isr J Psychiatry Relat Sci 22:83–87, 1985

Sugarman A: Psychoanalyzing a Vulcan: the importance of mental organization in treating Asperger's patients. Psychoanalytic Inquiry 31:222–239, 2011

Tanguay TE: Autism in DSM-5. Am J Psychiatry 168:1143–1144, 2011

Volkmar FR: Asperger's disorder: implications for psychoanalysis. Psychoanalytic Inquiry 31:334–344, 2011

Weiner MF: Dementia as a psychodynamic process, in The Dementias: Diagnosis and Management. Edited by Weiner MF. Washington, DC, American Psychiatric Press, 1991, pp 29–46

Weiner MF, Teri L: Psychological and Behavioral Management in The Dementias: Diagnosis and Management, 3rd Edition. Edited by Weiner MF, Lipton AM. Washington, DC, American Psychiatric Publishing, 2003, pp 181–218

Williams DDR, Garner J: People with dementia can remember: implications for care. Br J Psychiatry 172:379–380, 1998

Zabenko GS, Zabenko WN, McPherson S: A collaborative study of the emergence and clinical features of the major depressive syndrome of Alzheimer's disease. Am J Psychiatry 160:857–866, 2003

CHAPTER 14

CLUSTER A PERSONALITY DISORDERS

Paranoid, Schizoid, and Schizotypal

Paranoid Personality Disorder

Paranoid thinking is not in and of itself pathological. As described in Chapter 2, the paranoid-schizoid position is a basic mode of organizing experience that persists in the human psyche throughout the life cycle. In this mode, dangerous or unpleasant thoughts and feelings are split off, projected outward, and attributed to others. This mode is readily accessible in all kinds of group experiences, such as political conventions, sporting events, and institutional dynamics. At certain historical junctures, entire cultures have been pervaded by paranoid thinking, as in the "witch hunts" of the McCarthy era in this country.

The paranoid personality disorder, however, is a distinct pathological entity that is independent of cultural factors and is not a transient state growing out of the nexus of group dynamics. It involves a pervasive style of thinking, feeling, and relating to others that is extraordinarily rigid and unvarying. These individuals live within the paranoid-schizoid position. Seven common features compose the diagnostic criteria; at least four must be present to make the diagnosis (Box 14–1). Moreover, the patient's suspicious beliefs must stop short of being delusional and must occur independently of a psychotic diagnosis such as schizophrenia or delusional disorder.

Box 14–1. DSM-5 Criteria for Paranoid Personality Disorder

301.0 (F60.0)

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
   1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
   2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
   3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
   4. Reads hidden demeaning or threatening meanings into benign remarks or events.
   5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
   6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
   7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "paranoid personality disorder (premorbid)."

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As with most personality disorders, the key features of the paranoid personality disorder are ego-syntonic. A psychodynamic understanding of these individuals is based on limited experience of psychoanalytic or psychotherapeutic work with this population. In a study of 100 patients applying for psychoanalysis at the Columbia Psychoanalytic Center (Oldham and Skodol 1994), only 4 were diagnosed by rigorous personality disorder instruments as having paranoid personality disorder. The diagnosis is more likely to be made when patients present with symptoms of other disorders and are found to be comorbid for paranoid personality disorder. For example, in a pilot study of patients with panic disorder (Reich and Braginsky 1994), paranoid personality disorder was found in 54% of subjects presenting to a community mental health center.

Paranoid patients are often brought to treatment by family members or coworkers who are fed up with the patient's constant allegations and accusations. A boss, for example, may insist that an employee seek treatment—or look elsewhere for a job. A spouse who is tired of accusations of infidelity may use the threat of divorce to force the paranoid individual into treatment. Even when paranoid patients enter treatment willingly, they usually remain unconvinced that they are psychiatrically disturbed. Their presenting problems revolve around how others have mistreated and betrayed them.

The diagnostic criteria reflect a way of thinking that can be conceptualized as a distinctly paranoid cognitive style (Shapiro 1965). This style of thinking is characterized by an unrelenting search for hidden meanings, for clues to uncover the "truth" behind a situation's face value. The obvious, the superficial, and the apparent merely mask the reality. This endless search involves an intense hyperalertness of attention, evidenced by a guardedness related to this continuous attentional monitoring. A paranoid individual constantly scans the environment for anything out of the ordinary—a style of thinking that takes a considerable toll in physical and emotional tension. The paranoid patient is simply unable to relax.

Paranoid thinking is also characterized by a lack of flexibility. The most persuasive argument will generally have no impact on the rigid and unswerving beliefs of the paranoid person. In fact, individuals who attempt to argue with a person who has a paranoid personality disorder will simply find themselves becoming the target of suspicion. The paranoid person's thinking differs from that of the paranoid schizophrenic person in that it is not delusional. In fact, patients with paranoid personality disorder tend to have remarkably accurate perceptions of their environment. However, their judgments about those perceptions are generally impaired. Reality itself is not distorted; rather, the *significance* of apparent reality is misconstrued (Shapiro 1965). This characteristic cognitive style may be difficult to diagnose because the paranoid individual is often closemouthed and guarded. In fact, even projective testing may only identify the paranoid individual as a more-or-less normal person who is simply inhibited.

Psychodynamic Understanding

An understanding of the characteristics of the paranoid-schizoid position is essential to an understanding of the paranoid patient. As noted in Chapter 2, splitting is a central defense mechanism in this mode of organizing experience. Feelings of love and hate toward the same object must be separated from one another. Any movement toward integration creates intolerable anxiety that stems from the fear that the hatred will overpower and destroy the love. From the standpoint of the paranoid patient, emotional survival re-

quires the patient to split off all "badness" and project it onto outside figures. One manifestation of this defensive maneuver is that the normal internal world of aggressor and victim is transformed into a life experience in which the paranoid individual is constantly in the role of victim vis-à-vis external aggressors or persecutors. The view that paranoid patients have of the world thus relieves their internal tension between introjects. If a paranoid individual is forced to reinternalize what has been projected, the heightened internal tension will result in increased rigidity and defensiveness (Shapiro 1965).

Patients with paranoid personality disorder approach every relationship with the belief that the other person will eventually "slip up" and confirm their suspicions. In the paranoid-schizoid mode of existence, the patient lives in a state of unremitting anxiety stemming from a conviction that the world is peopled with untrustworthy and unpredictable strangers (Ogden 1986). Even when a stable, helpful therapist has worked with a paranoid patient over a long period, one minor disappointment can lead the patient to completely disregard the therapist's previous behavior and to feel—with unswerving conviction—that the therapist is untrustworthy. The therapist has been "unmasked." Thus, good experiences with a person in the past can be totally erased by the present situation. Moreover, the person with paranoid personality disorder tends to create self-fulfilling prophecies (Stone 2014). In other words, because the paranoid individual exudes distrust in interpersonal relationships, others begin to express various forms of anger at him, making him feel that his hunch that others did not like him was accurate.

Experience is literally taken at face value. Patients with paranoid personality disorder are unable to think, "It is *as if* this other person is trying to hurt me." Instead, they *know* that the other person harbors malevolent intentions. Similarly, in the transference relationship with the therapist, the paranoid patient is unable to say, "I feel that I am reacting to you *as if* you are as sadistic as my father was." The patient simply experiences the therapist as sadistic. Hence these patients can be viewed from the perspective of attachment theory as having a developmental failure in mentalization (Williams et al. 2005) because they often appear stuck in a psychic equivalence mode of thinking.

Projection and projective identification are two key defense mechanisms of the paranoid personality disorder. Projection substitutes an external threat for an internal one; projective identification goes a step farther. In addition to externalizing threats, projective identification "controls" persons in the environment by binding them to the paranoid person in highly pathological ways. The need to control others reflects the terribly low self-esteem at the core of paranoia (Meissner 1986). Deep down, the paranoid patient feels inferior, weak, and ineffectual. Thus, the grandiosity or sense of "spe-

cialness" often seen in these patients can be understood as a compensatory defense that makes up for feelings of inferiority. Those who actually seek treatment may have some feelings of depression or anxiety as a result of the failure of paranoid and grandiose defenses and a breakthrough of these underlying feelings of inadequacy (Meissner 1995).

The low self-esteem at the heart of the paranoid personality disorder leads these individuals to develop a keen sense of attunement to issues of rank and power. They are intensely concerned that persons in authority will humiliate them or expect them to be submissive (Shapiro 1965). They perceive threats to their autonomy as omnipresent. A recurring fear about their interpersonal relationships is that they will result in subjection to external control; they fear that anyone who tries to be close to them is secretly trying to take over. This concern may surface as a dread of passive homosexual impulses, originally described by Freud (1911/1958) in the case of the psychotically disturbed Judge Schreber. However, not all paranoid individuals are necessarily concerned about passive homosexual impulses. Overt homosexuality and paranoid personality disorder can and do exist in the same person. The main point is rather that these patients are concerned about *all* passive surrender to *all* impulses and to all persons (Shapiro 1965).

Successful treatment can provide a glimpse of what lies beneath the projective system: a good deal of depressive content (Meissner 1976) and diametrically opposing self representations. Coexisting with the special, entitled, grandiose version of the self is a weak, worthless, inferior polar opposite. Akhtar (1990) systematically examined these coexisting self representations and characterized them as follows:

> Outwardly, paranoid individuals are demanding, arrogant, mistrustful, driven, unromantic, moralistic, and acutely vigilant towards the external environment. Internally, however, they are frightened, timid, self-doubting, gullible, inconsiderate, vulnerable to erotomania, and cognitively unable to grasp the totality of actual events. (pp. 21–22)

Therapists who are aware of this other dimension of the paranoid personality can more easily empathize with these difficult patients.

The developmental failure to achieve object constancy is a characteristic of paranoid patients that organizes much of their behavior and thinking (Auchincloss and Weiss 1992; Blum 1981). Because they cannot maintain a loving connection with an internal object representation, they are convinced that love relationships are dangerous and unstable. To deal with the terrors associated with object inconstancy, the paranoid patient constructs fantasies of concrete and magical connectedness to objects (Auchincloss and Weiss 1992). Paranoid individuals impose an extreme either/or requirement on relationships. Either the object of their attention is thinking about them con-

tinuously or that person is emotionally indifferent to them—a thought paranoid patients find intolerable. This set of anxieties concerning indifference and connectedness is largely responsible for the willingness of paranoid patients to constrict their freedom in the service of feeling a concrete and magical connection to objects.

Treatment Approaches

Because of their suspiciousness, paranoid patients usually do poorly in group psychotherapy. Most treatment efforts must therefore be initiated in the context of individual therapy, despite the formidable challenge to the individual psychotherapist. As noted earlier, these patients often enter treatment under some external pressure, and they have the utmost difficulty trusting anyone. In light of these obstacles, the first step in psychotherapy should be to build a therapeutic alliance. This process is made more difficult by the tendency of paranoid patients to evoke defensive responses in others. The therapist is no exception, as the following vignette illustrates:

PATIENT: I'm really angry with you because I've been sitting in the waiting room for half an hour. You told me to be here at 9:30 today.
THERAPIST: No, that's not true. I said 10 A.M.
PATIENT: You said 9:30.
THERAPIST (*a little louder and more forcefully*): I said 10 o'clock. I wrote it down in my book.
PATIENT: You're trying to trick me! You won't admit you're wrong, so you try to make me think that I'm the one who's wrong.
THERAPIST (*louder still*): If I were wrong, I would admit it. On the contrary, I think you are the one who won't admit to being wrong, and you attribute that to me!
PATIENT: I'm not going to take this harassment. I'll find another therapist!

This slightly caricatured interaction illustrates the projective identification cycle that is extraordinarily common in paranoid patients. The patient treats the therapist as a persecuting bad object. The therapist feels coerced into being defensive and ends up giving an interpretation that attempts to force the projection back onto the patient. The patient responds by feeling attacked, misunderstood, and deceived. To avoid this escalating cycle, the therapist must empathize with the patient's need to project as a means of emotional survival. The therapist must be willing to serve as a container for feelings of hatred, badness, impotence, and despair (Epstein 1979; Gabbard 1991, 1996). Attempting to return such feelings prematurely will simply lead the patient to feel an increased internal tension and to become more rigid. The therapist must be able to accept blame, even to the point of acknowledging a lack of ability to help the patient (Epstein 1984). Most therapists have

strong countertransference resistances to accepting responsibility for a failing treatment; they just naturally become defensive when their patients accuse them of incompetence. However, by acknowledging the low self-esteem that creates the need to see fault in others, therapists can empathize with their patient's point of view and genuinely seek suggestions for how to make the treatment more productive. Becoming defensive is also a natural reaction to being accused of dishonesty. Defensiveness, however, may be misinterpreted as confirmation that the therapist has something to hide. Openness is by far the best policy with paranoid patients. If they act suspicious about the therapist's records or process notes, then the therapist would do well to share those notes with the patients and to thereby use them as a therapeutic intervention. Refusal to share notes will simply incite further paranoia.

Throughout the psychotherapy, particularly during the early phases of building an alliance, the therapist must avoid responding defensively—like everyone else in the patient's environment. The therapist should not challenge the patient's construction of events or the patient's perception of the therapist, no matter how negative. The therapist should merely ask for more detail and should empathize with the patient's feelings and perceptions. Above all, the therapist must resist the frequent countertransference tendency to be rid of undesirable projections by forcing them back onto the patient via premature interpretations (Epstein 1979). As in the previous example, interpretations of this kind will simply confirm the perception that the therapist is highly invested in attacking the patient. The same situation might be handled quite differently using these principles of technique:

PATIENT: I'm really angry with you because I've been sitting in the waiting room for half an hour. You told me to be here at 9:30 today.
THERAPIST: Let me see if I understand you correctly. Your understanding was that you were to see me today at 9:30 instead of 10 o'clock?
PATIENT: You said 9:30.
THERAPIST: I can certainly see why you might be angry at me then. Having to wait for someone for 30 minutes would make most people angry.
PATIENT: You admit that you told me to come at 9:30?
THERAPIST: Frankly, I don't remember saying that, but I'd like to hear more about your recall of that conversation so I can find out what I said to give you that impression.

In this scenario, the therapist accepts blame nondefensively without admitting to any fault. The therapist contains the patient's projection and seeks to find out more information about how it arose. By being willing to entertain the possibility of having indeed misled the patient, the therapist validates the patient's perception as legitimate and worthy of further discussion. Finally, the therapist does not attempt to return what has been projected in the form of an interpretation.

Therapists also need to empathize with the patient's tendency to be guarded. There is a certain adaptive quality in guardedness; paranoid patients who talk extensively about their perceptions are likely to alienate others. Therapists who allow for periods of silence and constriction instead of intrusively asking questions may help the patient to open up a bit more. Another technique for building an alliance is to focus on the patient's state of tension secondary to the extraordinary vigilance necessary to maintain the paranoid cognitive style. Comments such as "Your nerves must be shot" or "You must be exhausted after all of this" may help the patient feel understood. When the patient is willing to talk, the therapist should encourage elaboration, which may reveal historical antecedents to the current situation of stress (Meissner 1976). The therapist can also build an alliance by accepting the possibility that the patient's assertions may have some truth associated with them (Stone 2014). One can eventually help the patient consider that there is a distinction between something that is likely to happen and something that is extremely rare. Paranoid personality disorder goes hand in hand with empathic deficits, so another goal in psychotherapy is to help patients see how others might be thinking in contrast to their own way of thinking. In other words, the therapist helps the patient mentalize.

The overall goal of psychotherapeutic work with paranoid patients is to help them shift their perceptions of the origin of their problems from an external locus to an internal one. This shift can only follow an unhurried timetable that is unique to each patient. A second shift that is intimately connected with the first is the transformation of a paranoid mode of thinking into a depressive mode in which the patient allows himself or herself to experience feelings of vulnerability, weakness, inferiority, and defectiveness (Meissner 1995). The therapist must withstand repeated barrages of accusations and suspicions without becoming exasperated or despairing. As the patient opens up more, the therapist can begin to label the patient's feelings and thereby help the patient distinguish between emotions and reality (Meissner 1976). Therapists can also help their patients define gaps in their knowledge. For example, a therapist might ask, "Did your boss say that he hates you?" When the patient responds negatively to the question, the therapist can comment matter-of-factly about the patient's limited knowledge of the boss's feelings. Such questions must be worded tactfully and neutrally so as not to inordinately challenge the patient's view of the world. The therapist need not take a pro or con position in the matter but should only indicate that more information is necessary (Meissner 1976).

Throughout the entire psychotherapy process, the therapist must contain feelings rather than act on them. This containment will provide the patient with a new object relationship different from those previously encountered. The different experience is eventually internalized over time.

This relationship model of change is complemented by gradual changes in thinking. The key is for such patients to entertain a "creative doubt" (Meissner 1986) about their perceptions of the world. As patients move from the paranoid-schizoid position to encounter the depressive elements within, they begin to mentalize more effectively and to experience a sense of self that can mediate and interpret experience. Things may become "as if" they are a certain way rather than as *really* a certain way. Patients may also allow longer glimpses of their feelings of worthlessness and inferiority so that depressive elements can be worked through in the transference. In the most optimal circumstances, these patients can reveal a yearning for acceptance, love, and closeness that is associated with their frustration and disappointment with early figures in their lives (Meissner 1976, 1995). As a result, they can begin the process of mourning those attachments.

A brief report of the early stages of psychotherapy with a patient with paranoid personality disorder illustrates some of the technical principles described in the foregoing paragraphs. The bracketed comments below indicate how theory and technique relate in this case.

> Mr. AA was a 42-year-old accountant who had been on disability for a year because of his continual complaints of allergies to substances in the work environment. After receiving a promotion, he had moved into a new office where he had experienced a sudden onset of several troublesome physical symptoms, including headaches, sluggish thinking, tightening in the chest, blurred vision, generalized aching, weakness, easy fatigability, and lack of motivation. Mr. AA attributed these symptoms to the new paneling and carpeting in the office and to vibrations in the floor from the blower system. The ill effects began to dissipate whenever he left the office and were often gone by the time Mr. AA visited a doctor. He had had numerous diagnostic evaluations by various specialists, only one of whom had thought that there was any physical basis for the complaints. Mr. AA used this isolated opinion to vindicate his own view. He was pressured into psychotherapy by the management of his firm, who were concerned that his disability was becoming permanent. In the initial stages of therapy, Mr. AA denied any emotional problems other than marital tension, for which he blamed his wife. He spoke at length about his symptoms and maintained that he was convinced of their physical origin regardless of the negative findings of most of the specialists. [The patient reveals himself to be totally impervious to rational arguments from experts. He also displays grandiosity by believing that he knows more than the doctors.]
>
> When asked about his interpersonal relationships, Mr. AA said that he and his father were not on speaking terms because his father had deceived him in business deals. Moreover, he complained that his father was always harder on him than on all his brothers. He summarized his description of his father by saying that he was an unfair and untrustworthy man. Mr. AA went on to describe his wife as deceitful. She had "tricked" him into having a child by failing to use birth control and becoming pregnant. He said that he had

never forgiven his wife for her trickery—8 years previously—and he said that their marriage had been a disaster ever since. He said that the only way this situation could change would be for her to become more trustworthy. [The patient has projected malevolent persecuting objects onto close figures in his family and sees them as the source of all his problems. The patient himself acknowledges no contributions to these difficulties in family relationships and suggests that the only possible solutions involve change in others instead of in him.]

Throughout the first psychotherapy session, Mr. AA listened intently to the therapist, often asking for further clarification of comments. He seemed to be listening for hidden messages in the most benign communications. Mr. AA was also hyperalert to any slight body movements of the therapist, often misinterpreting them as indications of boredom or disinterest. After listening for some time, the therapist commented empathically, "You must feel awful right now. Your boss is on your back to get therapy, you feel physically miserable, and your wife and you are not speaking to each other." The patient responded to this empathic comment by opening up a little more, admitting that he had always been "thin-skinned." He acknowledged that he was often considerably disturbed by minor things that did not bother other people. [The therapist's empathic validation of Mr. AA's beleaguered self-esteem allowed him to feel understood. This beginning alliance allowed the patient to acknowledge a problem in himself for the first time, namely, that he was "thin-skinned."]

Mr. AA described his relationship with his son in cold, calculating terms by saying, "We're together more than average for the population at large." [This description reveals the inability of the paranoid personality to feel emotional warmth and tenderness in relationships because having such feelings would make him vulnerable to rejection or attack.] Mr. AA changed the subject to his concerns about the doctors who had examined him. He expressed a strong belief that all doctors are basically incompetent, and he seemed convinced that one doctor had almost caused him to have a cerebral hemorrhage with a certain medication. He described three psychiatrists who had previously examined him as all incompetent. He then asked the therapist if he knew of a particular nonpsychiatric medication. When the therapist admitted to being unfamiliar with the drug, Mr. AA quickly responded that the therapist was probably as much of a "quack" as the other doctors. [The paranoid person's fear of being controlled, allied with feelings of inferiority in "one-down" relationships, often leads to devaluation and demeaning of other people. By devaluing the therapist, Mr. AA reassures himself that he has nothing to envy and no reason to feel inferior.]

When Mr. AA continued to disparage the opinions of the many specialists he had seen, the therapist noted, "This must be very demoralizing for you." Mr. AA responded sharply, "You're trying to lead me on!" [Here the therapist's attempt to empathize by introducing a new feeling exceeded the patient's ability to admit to that feeling. The patient's reaction might have been more positive if the therapist had stayed closer to the words and feeling states that the patient himself had described.]

As Mr. AA continued to talk about his current state of affairs, he was able to acknowledge that he had found it difficult to adjust to disability and un-

employment after being in an executive position. Sensing an opening regarding the self-esteem issue, the therapist noted that being unable to work must have been quite a blow. Mr. AA responded by asking the therapist, "Do you think I am weak?" [Again the therapist's ability to empathize with the patient's low self-esteem rather than becoming defensive allowed Mr. AA to reveal concern about his underlying weakness and inferiority.]

Prevention of Violence

Although patients who have any of a broad variety of psychiatric disorders may become violent, paranoid patients pose a particular threat to psychiatrists. An understanding of the dynamics of paranoia may help avert assault. To prevent the escalation of aggression, psychiatrists should keep in mind several principles of management:

1. *Do everything possible to help the patient save face.* The core of paranoia is low self-esteem, so psychiatrists should empathize with the patient's experience and not challenge the truth of what the patient says. As in any treatment setting with a paranoid patient, the first task is to build a therapeutic alliance. In a study of 328 patients hospitalized on inpatient units (Beauford et al. 1997), patients who had a weaker therapeutic alliance at the time of admission were significantly more likely to display violent behavior during hospitalization. In a busy outpatient clinic, a resident who saw a paranoid patient for the first time suspected that he was not telling the truth about his current living situation. He told the patient that he was going to check up on his statement by calling the halfway house where the patient said he lived. As the resident reached in his desk drawer for the telephone book, the patient struck him in the face with his fist. This unfortunate incident leads directly into another major principle of violence prevention.
2. *Avoid arousing further suspicion.* Because of the basic distrust of these patients, all interventions must be geared to avoiding any increase in their paranoia. Each movement should be explained slowly and carefully. The movements themselves should be performed slowly and in clear view. You might say, for example, "Now I'm going to reach in my desk and get an appointment slip so that you'll know when our next meeting is." You should also avoid being overly friendly to these patients, because such behavior is in stark contrast to their usual experience and will simply further arouse their suspicions.
3. *Help the patient maintain a sense of control.* Control is of extraordinary importance to paranoid patients, who are likely to fear loss of control as much as the therapist fears it. The therapist must avoid panic at all costs. A therapist who displays fear that the patient will lose control will only

heighten the patient's own fears of losing control. Much of the anxiety among paranoid individuals stems from a fear that others will try to be in control; for this reason, anything the therapist can do to indicate respect for these patients' autonomy will help reduce their anxiety about passive surrender. Interventions should acknowledge their right to view the situation as they see it. For example, the therapist might tell such a patient, "I think your feelings are legitimate about the situation, given what you've been through, and I respect your right to feel that way."

4. *Always encourage the patient to verbalize rather than to violently act out anger.* Get the patient to discuss his or her anger in as much detail as possible. Encourage a consideration of the logical consequences of becoming violent. If possible, provide constructive alternatives to violence so that the patient can begin to see that there are other options. Supporting the anger as a legitimate reaction does not mean endorsing aggressive action. The therapist who feels immediately threatened may attempt to translate this threat into words. When one psychiatry resident sensed that a new patient was about to erupt in violence, he said, "I wonder if you're feeling like you want to hit me right now." The patient nodded in assent. The resident then replied, "Maybe if we go take a walk and you tell me about the feelings you're having, you'll be able to avoid acting on those feelings." This calm, matter-of-fact approach helped the patient feel more in control, and the patient actually thanked the resident for his help.
5. *Always give the patient plenty of breathing room.* The paranoid patient's fear of passive surrender to others is heightened by physical proximity. Avoid a seating arrangement where the patient feels trapped in the office. Violent individuals have been shown to need greater distance from others to feel secure (Kinzel 1971). Avoid sitting too close, as well as touching them, even in the most benign manner. One paranoid woman began carrying a gun to her therapy sessions after her therapist persisted in hugging her at the end of each session.
6. *Be attuned to your own countertransference in dealing with a potentially violent patient* (Felthous 1984). Countertransference denial is common both in hospital staff members and in therapists who work with paranoid individuals. They may fail to ask important historical questions for fear of confirming their worst fears about their patients' potential for violence. Treaters must acknowledge their own fears and then must avoid situations of jeopardy with patients who have been assaultive in the past. Denial may be more prominent with female patients because of gender stereotypes maintaining that men are more likely to be assaultive than women. In fact, the patterns of violence of male and female inpatients are similar, and women are just as likely as men to have attacked another person in the month before admission (Tardiff et al. 1997).

Therapists may also use countertransference projection to disavow their own aggression and externalize it onto their patients. Projective identification may provoke patients to violence when therapists see destructiveness and aggression only in their patients and not in themselves. One study of psychiatrists who have been assaulted by patients (Madden et al. 1976) found that 53% of the psychiatrists had in some way been provocative toward the patient prior to being assaulted.

Schizoid and Schizotypal Personality Disorders

In addition to paranoid personality disorder, Cluster A in DSM-5 (American Psychiatric Association 2013) subsumes schizoid and schizotypal personality disorders. Although these are distinct entities, they are considered together here because both the dynamic understanding of and the therapeutic approaches to these disorders have much in common.

The decision to separate schizoid and schizotypal personality disorders was largely based on the growing body of literature suggesting that schizotypal personality disorder is genetically linked to schizophrenia, whereas schizoid personality disorder is not (Kendler et al. 1981, 1995; Kety et al. 1971; Rosenthal et al. 1971). These studies suggest that schizotypal personality disorder is a muted version of schizophrenia, characterized by more or less intact reality testing, difficulties in relationships, and mild thought disturbances. Moreover, long-term follow-up of patients with schizotypal personality disorder suggests their outcomes are similar to those of patients with schizophrenia (McGlashan 1983). One study demonstrated that the risk for schizophrenia-related disorders in first-degree relatives of patients with schizotypal and paranoid personality disorders is significantly higher than in the first-degree relatives of patients with other personality disorders (Siever et al. 1990). Linkages between schizotypy and schizophrenia in the areas of attentional deficits and eye-tracking have also been demonstrated (O'Driscoll et al. 1998; Roitman et al. 1997). More recent research has noted that difficulties with semantic dysfunction in women with schizotypal personality disorder resemble those of schizophrenia (Niznikiewicz et al. 2002). Other studies have demonstrated similarities in volume reduction in the pulvinar in magnetic resonance imaging studies (Byne et al. 2001) and similar inhibitory deficits (Cadenhead et al. 2002). In a recent study (Asami et al. 2013), 54 men with schizotypal personality disorder who had never been exposed to neuroleptics were compared with 54 male healthy controls. Magnetic resonance imaging data revealed that the men with schizotypal personality disorder had significantly smaller gray matter volumes in the left superior temporal gyrus and widespread frontal, frontolimbic, and parietal

regions compared with the healthy controls. Moreover, these regional volume differences were strikingly correlated with negative symptoms. In other words, the greater the reduction in volume, the greater the presence of negative symptoms. This pattern is similar to that found in schizophrenia, but there was no progressive gray matter volume loss in schizotypal personality disorder as there is in schizophrenia. Poor nutrition in early childhood is also thought to play a role in the development of schizotypal personality (Venables and Raine 2012).

As part of the Collaborative Longitudinal Personality Disorders Study, participants with borderline, schizotypal, avoidant, or obsessive-compulsive personality disorder were studied over a 2-year period to determine the most prevalent and least changeable criteria (McGlashan et al. 2005). For schizotypal personality disorder the criteria that were most common and trait-like were ideas of reference, odd beliefs, paranoid ideation, and unusual experiences, all of which may represent milder variants of the cognitive distortions of reality that are central to the schizophrenia spectrum. The reality distortions exist in milder form with schizotypal personality and only intermittently become expressed behaviorally as coldness or oddness.

As Gunderson (1983) pointed out, persons with schizotypal personality disorder are much the same as those with schizoid personality disorder except that the definition of schizotypal personality disorder includes a few symptoms suggestive of an attenuated form of schizophrenia. In actuality, schizoid and schizotypal personality disorders form a continuum, so it is somewhat arbitrary to draw a dividing line between the two entities. An examination of the DSM-5 criteria for schizoid personality disorder (Box 14–2) and schizotypal personality disorder (Box 14–3) reveals that both disorders involve a good deal of social detachment and affective constriction.

Schizotypal patients themselves form a continuum, from those on one end who are much like schizoid patients (except for a few more oddities of behavior and communication) to those closer to schizophrenia who are prone to brief psychotic episodes. The ensuing discussion of the dynamic understanding of these conditions reflects the fact that similar therapeutic approaches are often helpful.

Psychodynamic Understanding

Schizoid and schizotypal patients often live on the fringes of society. They may be ridiculed as "weirdos," "oddballs," or "misfits," or they may merely be left alone to pursue a solitary and idiosyncratic existence. Their isolation and anhedonia may lead others to feel sorry for them and reach out to them. More often than not, however, the individuals who make such gestures give up after being repeatedly rebuffed. Family members may become so exasper-

Box 14–2. DSM-5 Criteria for Schizoid Personality Disorder

301.20 (F60.1)

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
   1. Neither desires nor enjoys close relationships, including being part of a family.
   2. Almost always chooses solitary activities.
   3. Has little, if any, interest in having sexual experiences with another person.
   4. Takes pleasure in few, if any, activities.
   5. Lacks close friends or confidants other than first-degree relatives.
   6. Appears indifferent to the praise or criticism of others.
   7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "schizoid personality disorder (premorbid)."

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ated that they force their schizoid relative into a treatment situation. Parents of adolescents or young adults may bring their son or daughter to a psychiatrist out of concern that their child is not getting enough out of life (Stone 1985). Other schizoid and schizotypal patients come to psychiatric treatment voluntarily because of painful loneliness.

The inner world of the schizoid patient may differ considerably from the individual's outward appearance. Indeed, these people are often a bundle of contradictions. Akhtar (1987) grouped these contradictions into overt and covert manifestations: "The schizoid individual is 'overtly' detached, self-sufficient, absent-minded, uninteresting, asexual, and idiosyncratically moral while 'covertly' being exquisitely sensitive, emotionally needy, acutely vigilant, creative, often perverse, and vulnerable to corruption" (p. 510). These polarities do not reflect conscious and unconscious personality traits. Rather, they represent a splitting or fragmentation of the self into different self representations that remain unintegrated. From a psychodynamic perspective, the "schizoid" designation reflects this fundamental splitting of the

Box 14–3. DSM-5 Criteria for Schizotypal Personality Disorder

301.22 (F21)

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
   1. Ideas of reference (excluding delusions of reference).
   2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
   3. Unusual perceptual experiences, including bodily illusions.
   4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
   5. Suspiciousness or paranoid ideation.
   6. Inappropriate or constricted affect.
   7. Behavior or appearance that is odd, eccentric, or peculiar.
   8. Lack of close friends or confidants other than first-degree relatives.
   9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)."

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self. The result is a diffuse identity—schizoid patients are not sure who they are, and they feel buffeted by highly conflictual thoughts, feelings, wishes, and urges. This identity diffusion makes relating to others problematic. Indeed, perhaps the most striking feature of schizoid and schizotypal patients is their apparent nonrelatedness to others. Psychoanalytic work with these patients suggests that they definitely have feelings and strivings for others but that the patients themselves are frozen developmentally at an early stage of relatedness (Lawner 1985). These patients seem to base their decision to be isolated on a conviction that their failure to receive what they needed from their mothers means that they can make no further attempt to receive

anything else from subsequent significant figures (Nachmani 1984). Schizoid patients may be trapped between two sets of anxieties: if they are too close, they may worry about engulfment and merger with the object, but if they are too distant, they fear loss and collapse (Williams et al. 2005).

Much of our understanding of the inner world of the schizoid patient derives from the work of the British object relations theorists. Balint (1979) viewed these patients as having a fundamental deficit in their ability to relate—a "basic fault" caused by significant inadequacies in the mothering they received as infants. He believed that the schizoid patient's difficulty in relating to others stems from this basic incapacity rather than from conflict (as in neurotic patients). Fairbairn (1954), perhaps the foremost contributor to our understanding of schizoid patients, viewed the schizoid retreat as a defense against a conflict between a wish to relate to others and a fear that one's neediness would harm others. The infant who initially perceives its mother as rejecting may withdraw from the world. However, the infant's neediness grows until it is experienced as insatiable. The infant then fears that its greed will devour the mother and leave it alone again. Hence, the very object that the infant most needs may be destroyed by its own incorporative strivings. Fairbairn termed this concern the "Little Red Riding Hood Fantasy," based on the fairy tale in which the little girl finds, to her horror, that her grandmother has disappeared, leaving her alone with her own projected oral greed—in the form of a devouring wolf.

Just as Little Red Riding Hood may project her greed onto the wolf, infants may project their own greed onto their mothers, whom they then view as devouring and dangerous. This infantile dilemma is frozen in time for schizoid patients, who first fear that they will devour others with their neediness and then fear being devoured by others. This fundamental dilemma of schizoid patients mandates that they will vacillate between their fear of driving others away by their neediness and their fear that others will smother or consume them. As a result, all relationships are experienced as dangerous and to be avoided. Because the decision to be nonrelated leaves the schizoid individual alone and empty, there is often a "schizoid compromise" (Guntrip 1968) in which the patient simultaneously clings to and rejects others.

Schizoid patients live under the constant threat of abandonment, persecution, and disintegration (Appel 1974). To take anything in from someone else risks the triggering of intense longings for dependency and merger. Love is equated with fusing with someone else, losing one's identity, and destroying the other person. Although the writing of the British School has focused on schizoid patients, the descriptions provided by Balint, Guntrip, and others apply to schizotypal patients as well (Stone 1985).

The schizoid patient's characteristic retreat from interpersonal relations may serve an important developmental function. Winnicott (1963/1965) be-

lieved that the isolation of the schizoid patient preserves an important authenticity that is absolutely sacred to the evolving self of the patient: "There is an intermediate stage in healthy development in which the patient's most important experience in relation to the good or potentially satisfying object is the refusal of it" (p. 182). The schizoid withdrawal is a way to communicate with the "true self" within instead of sacrificing that authenticity to artificial interactions with others that would lead to a "false self." Winnicott suggested that we all have this noncommunicating core and that we must respect the schizoid individual's right—and need—to be noncommunicative. Periods of extreme abstinence and isolation may help schizoid individuals get in touch with this sequestered self so that it can be integrated with other self representations (Eigen 1973).

Schizoid patients who allow their therapists to have access to their inner worlds will often reveal omnipotent fantasies. These usually accompany the reclusive aspects of the self to which the patient retreats. Like other aspects of the hidden self, they serve as a "sanctuary from exposure" (Grotstein 1977) to shore up fragile self-esteem and to allay anxiety about self-disintegration. Like paranoid patients, schizoid patients have omnipotent fantasies that increase in frequency in inverse proportion to their level of self-esteem (Nachmani 1984). Lacking good internal self and object representations to help accomplish essential work toward success in relationships or careers, schizoid patients employ fantasies of omnipotence to bypass such work and directly achieve their grandiose fantasies. Schizoid patients often feel a great deal of shame about their fantasies and are reluctant to share them with their therapists until they feel secure in the relationship.

Individual Psychotherapy

Like patients with paranoid personality disorder, patients with schizotypal and schizoid personality disorders do not often appear at the therapist's doorstep. In a national survey of clinicians, schizotypal personality disorder was the least widely treated entity of all personality disorders (Westen 1997). In the Columbia Psychoanalytic Center Study of 100 patients applying for psychoanalysis (Oldham and Skodol 1994), only 1 was diagnosed as having schizoid personality disorder, and none had the diagnosis of schizotypal personality disorder. Hence, much of the data accumulated about the psychotherapy and the psychotherapeutic treatment of these patients have been anecdotal, based on relatively small numbers.

Much like paranoid personality disorder, schizoid and schizotypal personality disorder are conditions that so rarely appear for treatment that we have no systematic studies on large samples that have attempted to measure the efficacy of psychotherapy. Clinical wisdom suggests that both schizo-

typal and schizoid patients can be helped with individual supportive therapy, dynamic group therapy, or combination of the two (Stone 2014). Because the prospect of the interactional demands of a group setting usually produces a good deal of anxiety, most of these patients will feel more comfortable beginning with an individual process. Much of the modern literature on the psychotherapy of schizoid and schizotypal personality disorders suggests that the mechanism of therapeutic action is likely to be internalization of a therapeutic relationship rather than interpretation of conflict (Appel 1974; Gabbard 1989; Nachmani 1984; Stone 1983, 1985; Winnicott 1963/1965).

The task of the therapist is to "thaw" the patient's frozen internal object relations by providing a new experience of relatedness. The schizoid style of relatedness emerges from inadequacies in the patient's earliest relationships with parental figures—what Epstein (1979) referred to as *primary maturational failure*. Throughout life, the patient has evoked similar reactions from those in the environment, producing *secondary maturational failures*. In other words, the schizoid patient may go through life distancing everyone. Therapists must figure out how to relate to the patient in a maturationally corrective way. Therapists must not allow themselves to be driven away or alienated like everyone else in the patient's life.

To say that the goal of therapy is to provide a new relationship for internalization is deceptively straightforward and simple. Yet this strategy presents formidable obstacles. First, the patient's basic mode of existence is nonrelatedness. The therapist is asking a nonrelating person to move in the direction of greater relatedness. As expected, the therapist's efforts to provide a new model of relatedness will be met with emotional distance and a good deal of silence.

Therapists who attempt to treat withdrawn schizoid patients must have extraordinary patience because of the slow, painstaking internalization process. They must also adopt a permissive, accepting attitude about silence. Specifically, silence must be viewed as more than simply resistance—it is also a specific form of nonverbal communication that may provide essential information about the patient.

The therapist's emotional reactions to the patient, however subtle, may be a primary source of information about the patient. When the silence is prolonged, therapists must be wary of turning the tables and projecting their own self and object representations onto the patient. This state of affairs is beautifully depicted in Ingmar Bergman's moving film *Persona,* in which a mute patient is treated by a nurse. After many unsuccessful attempts to get the patient to speak, the nurse becomes frustrated and begins to project aspects of herself onto the patient. Driven crazy, the nurse begins to treat the patient as an embodiment of her own internal world (Gabbard 1989).

This model of therapy requires therapists to receive their patient's projections and to monitor their own without being swept into countertransference acting-out. When therapists feel like quitting or giving up on a patient, they must view those feelings like any others in the process and attempt to understand them. As mentioned in Chapter 4 in the discussion of psychotherapy, the projective identifications might be diagnosed and understood only after the therapist has been "coerced" into playing a specific role vis-à-vis the patient. Therapists must silently note the interactions taking place between them and their patients and then use that information to inform subsequent interactions. Ogden (1982) summarized the therapist's task in such situations:

> The perspective of projective identification neither requires nor excludes the use of verbal interpretation; the therapist attempts to find a way of talking with and being with the patient that will constitute a medium through which the therapist may accept unintegrable aspects of the patient's internal object world and return them to the patient in a form that the patient can accept and learn from. (p. 42)

Indeed, a decision not to interpret may be the most therapeutically potent strategy with schizoid and schizotypal patients. If silence is interpreted as resistance, these patients may feel responsible and humiliated for their incapacity to communicate (Nachmani 1984). On the other hand, by refraining from interpretation and accepting silence, the therapist may legitimize the private, noncommunicative core of the self referred to by Winnicott (1963/1965). With certain patients, the therapist must respect the silent self. It may be the only viable technical approach to building a therapeutic alliance (Gabbard 1989).

Therapists greatly value interpersonal relatedness. We want to mean something to our patients. Accepting silent nonrelatedness runs counter to our training and psychological predisposition. Our natural tendency is to burden our patients with the expectation that they should be different than they are. Specifically, we want our patients to talk to us and to relate to us. However, that expectation means that we must ask patients to confront the very pain they avoid by schizoid withdrawal. Greater expectations from the therapist will paradoxically lead the patient to further detachment, as Searles (1986) observed:

> Winnicott's (1941/1958) concept of the…good-enough holding environment implies that the analyst be not merely relatively stable there, for the patient, but also relatively destructible (psychologically) by the patient, time and again, as the patient's persistent needs for autistic (omnipotent) functioning still require. Hence, the analyst needs intuitively to provide his own absence, perhaps as often as his own presence, to the patient at timely moments. (p. 351)

Certain patients will respond to this tolerant, empathic acceptance with greater openness in the therapeutic relationship. These patients may begin to speak about hidden aspects of the self, eventually integrating these into a more cohesive sense of self. At the beginning of a psychotherapy process, it is difficult to know which patients are likely to benefit from it. Stone (1983), writing about schizotypal (borderline schizophrenic) patients, suggested that those who do a bit better in psychotherapy have some depressive symptoms or some capacity for emotional warmth and empathy. He warned therapists to be wary of excessive countertransference expectations, because only limited progress can be expected. He also recommended that therapists resign themselves to the fact that many embarrassing topics may have to remain hidden for extended periods of time in the therapy (Stone 2001). Too much eagerness to probe may frighten or shame the patient. In Stone's view, therapists must be able to tolerate the disappointing possibility that their patients will progress only in areas other than relatedness. In general, those patients with better ego functioning (i.e., more intact reality testing, better judgment, smaller amounts of cognitive slippage) will do better in treatment than those patients with more profoundly disturbed ego functioning. With patients in the latter group, therapists may need to function as an auxiliary ego, helping patients supportively with various tasks such as reality testing, judgment, and self–object differentiation. Stone (2001) also pointed out that, like schizophrenic patients (see Chapter 7), schizotypal patients need more than expressive-supportive psychotherapy. Lower-functioning schizotypal patients also need social skills training, reeducation, and various social supports.

Dynamic Group Psychotherapy

In general, schizoid patients are prime candidates for dynamic group psychotherapy (Appel 1974; Azima 1983). Group therapy is oriented toward helping patients with socialization, which is exactly where schizoid patients suffer most. It is also a setting in which a good deal of new parenting can take place. For many schizoid patients, their peers in a group process can function as a reconstructed family, eventually being internalized by these patients to counterbalance their more negative and frightening internal objects (Appel 1974).

Such patients can benefit considerably simply by having regular exposure to others. Some schizoid patients literally have no social outlets beyond their group therapy sessions. As they begin to feel accepted and to find that their worst fears are not realized, they gradually become more comfortable with people. In a manner similar to the individual therapy process described earlier, the reactions of other group members may provide a corrective expe-

rience that runs counter to all previous relationship experiences. Some difficulties that arise in the group psychotherapy of schizoid patients include resentment from other patients who have to "spill their guts" while the schizoid patient remains silent. These feelings may lead to a kind of "ganging up" to force the schizoid patient to talk. At such moments, the therapist must support the schizoid member of the group and help the other patients accept that patient's need to be silent (Azima 1983). The other patients may also simply ignore a withdrawn schizoid patient and proceed as if that patient were not there. In these instances, the therapist's task is to bring the patient into the group by pointing out how a pattern that takes place outside the group is repeating itself inside the group. Schizotypal patients tend to benefit from group therapy much as schizoid patients do, but those whose behavior is bizarre or whose thinking is psychotic may become scapegoats because they are simply too different from other members of the group. With such patients, individual therapy alone may be the preferred modality.

A combination of group and individual psychotherapy is ideal for many schizoid patients because the social field they encounter in the group can be discussed and processed with their individual psychotherapist. A significant number of schizoid patients will feel, however, that receiving a recommendation for group therapy is like "being thrown to the lions." They may even feel betrayed when their therapist makes the suggestion. A preliminary step to group referral is often the working through of these patients' fantasies about what will happen in group therapy.

The following case example illustrates some of the unique advantages of group psychotherapy for some schizoid patients.

> Mr. BB was a 23-year-old single man with schizoid personality disorder. He worked as a nurse's aide on the night shift in a nursing home and took daytime classes at a local university. He liked working at night because very few interpersonal demands were made on him. His supervisor frequently slept, so he was free to read novels. When he was not sleeping, Mr. BB would spend many hours in vigorous bodybuilding exercises. He would then pose nude in front of the mirror and flex his muscles and admire himself. Much of the posing and flexing was accompanied by omnipotent fantasies of becoming an Olympic decathlon winner. He also imagined that if he achieved a certain level of bodily perfection, he would then be attractive to a girl in one of his college classes who he could never bring himself to speak to.
>
> Mr. BB was deeply concerned about the fact that he had been adopted. He spoke about it with great shame, as though convinced that it reflected some inherent flaw. In his view, the early rejection by his biological mother was a sign that he was so inherently undesirable that others would also certainly reject him if given the chance.
>
> Like many schizoid patients, Mr. BB had a perverse streak that took the form of exhibitionism. He would place himself in situations in which women

would come upon him in the nude. He would then act surprised and immediately leave the scene so as to avoid prosecution. However, the sexual pleasure he derived from this activity led him into more and more risky adventures. He once switched the men's and women's labels on the locker room doors in a gymnasium so that women would enter the men's locker room and find him standing there nude, drying himself after showering.

Mr. BB eventually came to an outpatient clinic where he sought group psychotherapy. He was concerned that his exhibitionism was getting out of hand and might lead to legal consequences, and he was genuinely disturbed by the loneliness of his existence. He sought group psychotherapy because he had previously tried individual psychotherapy for 2 years. He reported that he had remained silent throughout practically the entire therapy. Finally, he and the therapist had mutually decided that there was no point in continuing. Mr. BB also reported that he had a strong desire to overcome his fear of other people, and he believed that group therapy might be a good way to deal with that fear.

Mr. BB began a dynamic group psychotherapy process with a reasonably high-functioning group of other patients with assorted personality disorders. He attended regularly but sat silently through much of the group's discussion. Little by little, he was able to reveal more and more about himself. Something of a breakthrough occurred when he mustered enough courage to talk about the female classmate who was the object of his fantasies. One female patient in the group responded by saying, "Why don't you ask her out? You're an attractive man." Moved by this comment, Mr. BB replied that no one had ever told him that before.

The support and positive feedback this patient received from other group members bolstered his self-esteem and allowed him to speak more frequently and more openly. When he finally was able to discuss his exhibitionism, he experienced considerable relief that no one recoiled in horror at his revelation.

After several years of group therapy, Mr. BB's anxieties about relationships and his self-regard had improved to the point that he was able to begin dating and to form some appropriate peer relationships with males. The episodes of exhibitionism gradually decreased, although they tended to recur whenever the group took a vacation and Mr. BB felt abandoned by the therapist and his fellow patients.

The case of Mr. BB illustrates how the overt absence of object relations in schizoid personality disorder may be accompanied by intense fantasies of relatedness and by covert sexual activities of a perverse nature. Long periods of exercise are also fairly common in schizoid and schizotypal individuals. Physical activity of this kind may serve to "burn off" sexual energy or, as in the case of Mr. BB, may also be a way to build self-esteem by fantasizing that others will find the individual more attractive as a result of such efforts.

Although a number of perversions are commonly found in schizoid individuals, exhibitionism seems to hold a particular significance for these patients. Fairbairn (1954) observed that schizoid individuals frequently

overvalue their mental contents, perceiving them as extraordinarily precious. They fear giving anything of themselves because in so doing they would deplete their narcissistically prized contents. Fairbairn noted that schizoid patients commonly use exhibitionism as a defense against the fear of giving. To be more exact, "showing" becomes a substitute for "giving," because the latter carries the fear of losing something precious, whereas the former does not. Although the exhibitionism was overt in the case of Mr. BB, it frequently appears in sublimated forms, such as involvement in the performing arts.

Group psychotherapy provided Mr. BB with a new series of relationships to internalize. The relatedness with his fellow patients (and with the therapist) disconfirmed his expectations of how others would respond to him. Instead of being alienated by him, the group members accepted him as he was and confirmed his desirability as a person. Thus the validation of other patients in group therapy may have a more powerful impact on a schizoid patient than similar validation by an individual therapist. The schizoid patient may write off the positive regard of the therapist as an attitude contrived for therapeutic effect; the therapist is "just doing his job."

Many schizoid and schizotypal patients have illness that is much more refractory to treatment than did Mr. BB. As Stone (2001) suggested, therapists must genuinely respect their patient's need to be different and must not feel compelled to transform a patient into someone else. In treating schizoid and schizotypal patients, we would all be well advised to remember the wisdom of Thoreau: "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away" (Thoreau 1854/1950, p. 290).

References

Akhtar S: Schizoid personality disorder: a synthesis of developmental, dynamic, and descriptive features. Am J Psychother 61:499–518, 1987

Akhtar S: Paranoid personality disorder: synthesis of developmental, dynamic, and descriptive features. Am J Psychother 44:5–25, 1990

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Appel G: An approach to the treatment of schizoid phenomena. Psychoanal Rev 61: 99–113, 1974

Asami T, Whitford TJ, Bouix S, et al: Globally and locally reduced MRI gray matter volumes in neuroleptic-naive men with schizotypal personality disorder: association with negative symptoms. JAMA Psychiatry 70:361–372, 2013

Auchincloss EL, Weiss RW: Paranoid character and the intolerance of indifference. J Am Psychoanal Assoc 40:1013–1037, 1992

Azima FJC: Group psychotherapy with personality disorders, in Comprehensive Group Psychotherapy, 2nd Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1983, pp 262–268

Balint M: The Basic Fault: Therapeutic Aspects of Regression. New York, Brunner/Mazel, 1979

Beauford JE, McNiel DE, Binder RL: Utility of the initial therapeutic alliance in evaluating psychiatric patients' risk of violence. Am J Psychiatry 154:1272–1276, 1997

Blum HP: Object inconstancy and paranoid conspiracy. J Am Psychoanal Assoc 29: 789–813, 1981

Byne W, Buchsbaum MS, Kemether E, et al: Magnetic resonance imaging of the thalamic mediodorsal nucleus and pulvinar in schizophrenia and schizotypal personality disorder. Arch Gen Psychiatry 58:133–140, 2001

Cadenhead KS, Light GA, Geyer NA, et al: Neurobiological measures of schizotypal personality disorder: defining an inhibitory endophenotype. Am J Psychiatry 159: 869–871, 2002

Eigen M: Abstinence and the schizoid ego. Int J Psychoanal 54:493–498, 1973

Epstein L: Countertransference with borderline patients, in Countertransference. Edited by Epstein L, Feiner AH. New York, Jason Aronson, 1979, pp 375–405

Epstein L: An interpersonal–object relations perspective on working with destructive aggression. Contemp Psychoanal 20:651–662, 1984

Fairbairn WRD: An Object-Relations Theory of the Personality. New York, Basic Books, 1954

Felthous AR: Preventing assaults on a psychiatric inpatient ward. Hosp Community Psychiatry 35:1223–1226, 1984

Freud S: Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides) (1911), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 1–82

Gabbard GO: On "doing nothing" in the psychoanalytic treatment of the refractory borderline patient. Int J Psychoanal 70:527–534, 1989

Gabbard GO: Technical approaches to transference hate in the analysis of borderline patients. Int J Psychoanal 72:625–637, 1991

Gabbard GO: Love and Hate in the Analytic Setting. Northvale, NJ, Jason Aronson, 1996

Grotstein JS: The psychoanalytic concept of schizophrenia, I: the dilemma. Int J Psychoanal 58:403–425, 1977

Gunderson JG: DSM-III diagnoses of personality disorders, in Current Perspectives on Personality Disorders. Edited by Frosch JP. Washington, DC, American Psychiatric Press, 1983, pp 20–39

Guntrip H: Schizoid Phenomena, Object-Relations, and the Self. New York, International Universities Press, 1968

Kendler KS, Gruenberg AM, Strauss JS: An independent analysis of the Copenhagen sample of the Danish adoption study of schizophrenia, II: the relationship between schizotypal personality disorder and schizophrenia. Arch Gen Psychiatry 38:982–984, 1981

Kendler KS, McGuire M, Gruenberg AM, et al: Schizotypal symptoms and signs in the Roscommon Family Study: the factors, structure and familial relationship with psychotic and affective disorders. Arch Gen Psychiatry 52:296–303, 1995

Kety SS, Rosenthal D, Wender PH, et al: Mental illness in the biological and adoptive families of adopted schizophrenics. Am J Psychiatry 128:302–306, 1971

Kinzel AF: Violent behavior in prisons, in Dynamics of Violence. Edited by Fawcett J. Chicago, IL, American Medical Association, 1971

Lawner P: Character rigidity and resistance to awareness of the transference. Issues in Ego Psychology 8:36–41, 1985

Madden DJ, Lion JR, Penna MW: Assaults on psychiatrists by patients. Am J Psychiatry 133:422–425, 1976

McGlashan TH: The borderline syndrome, II: is it a variant of schizophrenia or affective disorder? Arch Gen Psychiatry 40:1319–1323, 1983

McGlashan TH, Grilo CM, Sanislow CA, et al: Two-year prevalence and stability of individual DSM-IV criteria for schizotypal, borderline, avoidant and obsessive-compulsive personality disorders: toward a hybrid model of Axis II disorders. Am J Psychiatry 162:883–889, 2005

Meissner WW: Psychotherapeutic schema based on the paranoid process. Int J Psychoanal Psychother 5:87–114, 1976

Meissner WW: Psychotherapy and the Paranoid Process. Northvale, NJ, Jason Aronson, 1986

Meissner WW: Paranoid personality disorder, in Treatments of Psychiatric Disorders, 2nd Edition, Vol 2. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1995, pp 2249–2259

Nachmani G: Hesitation, perplexity, and annoyance at opportunity. Contemp Psychoanal 20:448–457, 1984

Niznikiewicz MA, Shenton ME, Voglnaier M: Semantic dysfunction in women with schizotypal personality disorder. Am J Psychiatry 159:1767–1774, 2002

O'Driscoll GA, Lezenweger MF, Holzman PS: Antisaccades and smooth pursuit eye tracking and schizotypy. Arch Gen Psychiatry 55:837–843, 1998

Ogden TH: Projective Identification and Psychotherapeutic Technique. New York, Jason Aronson, 1982

Ogden TH: The Matrix of the Mind: Object Relations and the Psychoanalytic Dialogue. Northvale, NJ, Jason Aronson, 1986

Oldham JM, Skodol AE: Do patients with paranoid personality disorder seek psychoanalysis?, in Paranoia: New Psychoanalytic Perspectives. Edited by Oldham JM, Bone S. Madison, CT, International Universities Press, 1994, pp 151–166

Reich J, Braginsky Y: Paranoid personality traits in a panic disorder population: a pilot study. Compr Psychiatry 35:260–264, 1994

Roitman SEL, Corblatt BA, Bergman A, et al: Attentional functioning in schizotypal personality disorder. Am J Psychiatry 154:655–660, 1997

Rosenthal D, Wender PH, Kety SS, et al: The adopted-away offspring of schizophrenics. Am J Psychiatry 128:307–311, 1971

Searles HF: My Work With Borderline Patients. Northvale, NJ, Jason Aronson, 1986

Shapiro D: Neurotic Styles. New York, Basic Books, 1965

Siever LJ, Silverman JM, Horvath TB, et al: Increased morbid risk for schizophrenia-related disorders in relatives of schizotypal personality disordered patients. Arch Gen Psychiatry 47:634–640, 1990

Stone MH: Psychotherapy with schizotypal borderline patients. J Am Acad Psychoanal 11:87–111, 1983

Stone MH: Schizotypal personality: psychotherapeutic aspects. Schizophr Bull 11:576–589, 1985

Stone MH: Schizoid and schizotypal personality disorders, in Treatments of Psychiatric Disorders, 3rd Edition, Vol 2. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2001, pp 2237–2250

Stone MH: Paranoid, schizoid, and schizotypal personality disorders, in Gabbard's Treatments of Psychiatric Disorders. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Tardiff K, Marzuk PM, Leon AC, et al: Violence by patients admitted to a private psychiatric hospital. Am J Psychiatry 154:88–93, 1997

Thoreau HD: Walden (1854), in Walden and Other Writings of Henry David Thoreau. Edited by Atkinson B. New York, The Modern Library, 1950, p 290

Venables PH, Raine A: Poor nutrition at age 3 and schizotypal personality at age 23: the mediating role of age 11 cognitive functioning. Am J Psychiatry 169:822–830, 2012

Westen D: Divergences between clinical and research methods for assessing personality disorders: implications for research and the evolution of Axis II. Am J Psychiatry 154:895–903, 1997

Williams P, Haigh R, Fowler D: Paranoid, schizoid, and schizotypal personality disorders, in The Oxford Textbook of Psychotherapy. Edited by Gabbard GO, Beck J, Holmes JA. Oxford, UK, Oxford University Press, 2005

Winnicott DW: The observation of infants in a set situation (1941), in Through Paediatrics to Psycho-Analysis. New York, Basic Books, 1958, pp 52–69

Winnicott DW: Communicating and not communicating leading to a study of certain opposites (1963), in The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. New York, International Universities Press, 1965, pp 179–192

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CHAPTER
15

CLUSTER B PERSONALITY DISORDERS

Borderline

Although borderline personality disorder was once considered a chronic condition that was refractory to most treatments, in the past two decades an extraordinary body of literature has emerged that paints a different picture. The complex etiology involving neurobiological features, including genetic contributions, family factors, and intrapsychic contributions, has led to a much broader and deeper understanding of the condition. Moreover, long-term follow-up studies suggest a favorable prognosis in most cases. Finally, numerous studies of treatment based on different theoretical perspectives and using rigorous research designs have shown that most patients with this diagnosis respond well to treatment. A brief historical survey of this diagnostic entity will trace the evolution of our understanding of borderline personality disorder (BPD) in the context of American psychiatry.

Evolution of the Term

In the late 1930s and throughout the 1940s, clinicians began to describe certain patients who were not sick enough to be labeled schizophrenic but who were far too disturbed for classical psychoanalytic treatment. In an effort to capture the "in between" state typical of these patients, Hoch and Polatin (1949) referred to this group as having pseudoneurotic schizophrenia charac-

terized by a symptomatic pattern of "panneurosis," "pananxiety," and "pansexuality." Robert Knight (1953) further characterized this ill-defined group by focusing on several impairments in ego functioning, including the inability to plan realistically, the incapacity to defend against primitive impulses, and the predominance of primary process thinking over secondary process thinking.

These early contributors were observing a "messy" syndrome that did not fit well into preexisting diagnostic rubrics. Grinker et al. (1968) brought some diagnostic rigor to the syndrome in the early 1960s with their statistical analysis of approximately 60 such patients who were hospitalized in Chicago. A cluster analysis of data on these patients suggested that there were four subgroups of borderline patients. These patients appeared to occupy a continuum from the "psychotic border" (type I) all the way to the "neurotic border" (type IV). In between the two extremes could be found a group with predominantly negative affects and difficulty maintaining stable interpersonal relationships (type II), and another group (type III) characterized by a generalized lack of identity, resulting in a need to borrow identity from others.

Grinker et al. (1968) also attempted to identify common denominators in the borderline syndrome that were present regardless of the subtype. They came up with the following four key features: 1) anger as the main or only affect, 2) defects in interpersonal relationships, 3) absence of consistent self-identity, and 4) pervasive depression. One of the most significant contributions of this empirical study was the finding that the borderline syndrome was clearly distinct from schizophrenia. Grinker and colleagues found that these patients do not deteriorate into frank schizophrenia over time. Rather, they are stably unstable (Schmideberg 1959) throughout the course of their illness. This discovery helped refute the belief some skeptics held that borderline patients were actually schizophrenic.

By 1990, Gunderson and his colleagues (Zanarini et al. 1990) were able to identify clear discriminating features based on research that focused on descriptive characteristics of the borderline syndrome (Table 15–1).

Many of these criteria are interrelated. Borderline patients are consumed with establishing exclusive one-to-one relationships with no risk whatsoever of abandonment. They may demand such relationships with an air of entitlement that overwhelms and alienates others. Moreover, when they do become close with another person, a set of twin anxieties is activated. On the one hand, they begin to worry that they will be engulfed by the other person and lose their own identity in this primitive merger fantasy. On the other hand, they experience anxiety verging on panic related to the conviction that they are about to be rejected or abandoned at any moment. To prevent being alone, borderline patients may resort to wrist-cutting or suicidal gestures, hoping to elicit rescue by the person to whom they are attached. Cognitive distortions, such as quasi-psychotic thought (defined as transient, circumscribed, and/or

TABLE 15–1. Discriminating characteristics of borderline personality disorder

Quasi-psychotic thought	Demandingness/entitlement
Self-mutilation	Treatment regressions
Manipulative suicide efforts	Countertransference difficulties
Abandonment/engulfment/annihilation concerns	

Source. Based on Zanarini et al. 1990.

atypical strains on reality testing), also may occur in the context of interpersonal relationships. Near-delusional perceptions of abandonment by loved ones are common, and psychotic transference regressions may appear when patients become attached to their therapists. Clinicians who witness this kaleidoscopic display of shifting ego states are prone to a variety of intense countertransference reactions, including rescue fantasies, guilt feelings, transgressions of professional boundaries, rage and hatred, anxiety and terror, and profound feelings of helplessness (Gabbard 1993; Gabbard and Wilkinson 1994).

Whereas Gunderson and Grinker et al. focused primarily on descriptive diagnostic criteria, Otto Kernberg (1967, 1975) sought to characterize borderline patients from a psychoanalytic perspective. Using a combined ego psychological–object relations approach, he coined the term *borderline personality organization* to encompass a group of patients who showed characteristic patterns of ego weakness, primitive defensive operations, and problematic object relations. He observed a variety of symptoms in these patients, including free-floating anxiety, obsessive-compulsive symptoms, multiple phobias, dissociative reactions, hypochondriacal preoccupations, conversion symptoms, paranoid trends, polymorphous perverse sexuality, and substance abuse. Kernberg cautioned, however, that descriptive symptoms were not sufficient for a definitive diagnosis. He believed instead that the diagnosis rested on a sophisticated structural analysis that revealed four key features (Table 15–2).

1. *Nonspecific manifestations of ego weakness.* One aspect of ego functioning is the capacity to delay the discharge of impulses and to modulate affects such as anxiety. Borderline patients, in Kernberg's view, are unable to marshal ego forces to perform those functions because of inherent nonspecific weaknesses. Similarly, they have a difficult time sublimating powerful drives and using their conscience to guide behavior.
2. *Shift toward primary process thinking.* Like Robert Knight, Kernberg noted that these patients tend to regress into psychotic-like thinking in the

TABLE 15–2. Kernberg's criteria for borderline personality organization

I. Nonspecific manifestations of ego weakness
A. Lack of anxiety tolerance
B. Lack of impulse control
C. Lack of developed subliminatory channels
II. Shift toward primary process thinking
III. Specific defensive operations
A. Splitting
B. Primitive idealization
C. Early forms of projection, especially projective identification
D. Denial
E. Omnipotence and devaluation
IV. Pathological internalized object relations

Source. Based on Kernberg 1975.

absence of structure or under the pressure of strong affects. However, these shifts primarily occur in the context of generally intact reality testing.

3. *Specific defensive operations.* Foremost among these defenses was splitting, which Kernberg viewed as an active process of separating contradictory introjects and affects from one another (see Chapter 2). Splitting operations in the person with borderline personality organization manifest themselves clinically as follows: a) an alternating expression of contradictory behaviors and attitudes, which the patient regards with a lack of concern and bland denial; b) a compartmentalization of all persons in the patient's environment into "all good" and "all bad" camps, with frequent oscillations between camps for a given individual; and c) coexisting contradictory views and images of oneself (self representations) that alternate in their dominance from day to day and from hour to hour.

A 41-year-old Catholic priest was admitted to a psychiatric hospital upon discovery that he had engaged in extensive sexual behavior with children of both sexes. Shortly after admission, his routine laboratory studies revealed a positive test for syphilis. When confronted with the lab result, the priest responded, "I don't know how that's possible. I'm a celibate priest." The resident treating the priest simply pointed out that the patient had been admitted to the hospital because of his extensive sexual activity with minors. The priest blandly responded to this confrontation by saying, "What do you expect? I'm only human."

This clinical vignette illustrates how contradictory self representations coexist in the borderline patient—a "celibate priest" coexisted with a promiscuous, bisexual pedophile. Moreover, the priest's matter-of-fact response was typical of the bland denial that many borderline patients display when confronted with the splitting maneuvers they employ. Other defenses, such as primitive idealization, omnipotence, and devaluation, similarly reflect splitting tendencies (i.e., others are seen in wholly positive or wholly negative terms). Projective identification, in which self or object representations are split off and projected onto others in an effort to control them, is another prominent defense in borderline personality organization, according to Kernberg.

4. *Pathological internalized object relations.* As a result of splitting, the person with borderline personality organization does not view other people as having a mixture of positive and negative qualities. Instead, others are divided into polar extremes and are regarded, in the words of one patient, as "either gods or devils." These individuals cannot integrate libidinal and aggressive aspects of others, which inhibits their ability to truly appreciate the internal experiences of other people. Their perceptions of others may alternate daily between idealization and devaluation, which can be highly disturbing for anyone in a relationship with such a person. Similarly, their inability to integrate positive and negative representations of the self results in profound identity diffusion, as illustrated by the previous example of the priest.

Kernberg's concept of borderline personality organization is distinct from the actual phenomenological characteristics that identify a specific personality disorder. In other words, his term encompasses many different personality disorders. In his view, patients with narcissistic, antisocial, schizoid, paranoid, infantile, and cyclothymic personality disorders, for example, are all characterized by an underlying borderline personality organization.

Personality disorder diagnoses in general are lacking in discriminant validity, because a patient who receives one personality disorder diagnosis may receive four to six additional personality disorder diagnoses (Oldham et al. 1992). This overlap is particularly prevalent among Cluster B personality disorders, for which many patients have characteristics belonging to two or more of the conditions in that cluster. To avoid conceptual confusion (and because related personality disorders, such as paranoid, schizoid, narcissistic, antisocial, and histrionic, are discussed at length in other chapters of this volume), the discussion in this chapter is confined to those patients with the borderline features described by DSM-5 (American Psychiatric Association 2013) (Box 15–1).

Box 15–1. DSM-5 Criteria for Borderline Personality Disorder

301.83 (F60.3)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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Demographic Features and Course of Illness

Epidemiological studies in the United States and Norway suggest that the prevalence of BPD is somewhere between 0.7% and 1.8% of the general population (Swartz et al. 1990; Torgersen et al. 2001). In clinical populations, however, the prevalence is somewhere between 15% and 25% (Gunderson 2014; Gunderson and Zanarini 1987). In almost all samples, women are far more frequently diagnosed with BPD, and thus 71% to 73% of most samples are female (Widiger and Weissman 1991). Male borderline patients tend to manifest symptomatology that presents a somewhat different clinical picture than the prototypical female patient with BPD. Zlotnick et al. (2002) assessed 130 outpatients with BPD for various lifetime impulse-related disorders. Men with BPD were more likely to have substance abuse disorders and

meet criteria for antisocial personality disorder. Women with BPD were more likely to have eating disorders. Hence males with BPD are often labeled antisocial rather than borderline.

Recent research suggests that although outcomes of personality disorder are heterogeneous, most patients do well (Paris 2012). Two prospective long-range follow-up studies (Gunderson et al. 2011; Zanarini et al. 2012) demonstrate that the major acute symptoms of the disorder, such as impulsivity, self-harm, suicidality, and emotional dysregulation, will remit naturally, even without treatment, relatively early in the course of the disorder. In the 10-year course of 175 patients with BPD in the Collaborative Longitudinal Personality Disorders Study (Gunderson et al. 2011), 85% of the patients had remitted. Rates of relapse were low, but persistent difficulties in social functioning were present. The 16-year prospective follow-up study from McLean (Zanarini et al. 2012) had similar findings. Patients with BPD had rates of symptomatic remission similar to other personality disorders. However, a 2-year symptomatic remission was much more common than a 2-year recovery, defined as concurrent symptomatic remission *and* good social and vocational functioning. Only 60% of the borderline patients attained a 2-year recovery, whereas 85% of the other personality disorder subjects achieved similar recovery. These figures dropped to 40% and 75%, respectively, when recoveries lasting 8 years were examined.

These results are encouraging, although they also indicate that even individuals who no longer meet criteria for BPD may continue to struggle and require treatment. On the other hand, few patients with borderline personality disorder appear to require lifelong treatment (Paris 2012). Most patients are able to settle into life and cease the continuous contemplation of suicide. As Paris (2012) notes, "Borderline personality disorder is not, as once thought, a life sentence" (p. 446). The prognosis appears to be much better than that of bipolar disorder. In the McLean study, of the 264 borderline patients who continued participation, only 13 died by suicide, and 13 died of other causes. Hence, the suicide rate is probably in the range of 3%–5%.

Psychodynamic Understanding and Etiology

Early attempts to understand the causes of borderline personality disorder focused on overinvolvement of maternal figures who were conflicted about allowing the child to separate, leading to anxieties about separation and abandonment in the child, who eventually grew up to have the diagnosis of BPD (Mahler et al. 1975; Masterson and Rinsley 1975). Others focused more on a deficit or "insufficiency" model (Adler 1985) and suggested that unreliable mothering would cause borderline patients to have difficulty develop-

ing a holding and shooting introject to sustain them during periods of absence.

All of the psychodynamic models have been challenged to some extent by the empirical research literature. For example, maternal overinvolvement has been questioned in a series of studies (Frank and Hoffman 1986; Frank and Paris 1981; Goldberg et al. 1985; Gunderson et al. 1980; Paris and Frank 1989; Paris and Zweig-Frank 1992; Soloff and Millward 1983; Zweig-Frank and Paris 1991) that collectively suggest three overarching conclusions (Zanarini and Frankenburg 1997): 1) borderline patients generally view their maternal relationships as distant, highly conflictual, or uninvolved; 2) the father's failure to be present is an even more discriminating aspect of the families of origin than the maternal relationship; and 3) disturbed relationships with both the mother and the father may be more pathogenic as well as more specific for BPD than those with either parent alone.

These findings suggest that neglect may be a more significant etiological factor than overinvolvement. One elegantly designed prospective study (Johnson et al. 1999) found that neglect in childhood was associated with an increase in BPD symptoms as well as those connected with several other personality disorders.

Psychodynamic theories emphasizing the significance of separation and abandonment have received some confirmation from studies measuring the prevalence of early separations and loss in the childhood histories of patients with BPD (Akiskal et al. 1985; Links et al. 1988; Walsh 1977; Zanarini et al. 1989a). In a study (Zanarini and Frankenburg 1997) comparing borderline patients with those who are diagnosed with other personality disorders, psychotic patients, and affectively disturbed patients, those with BPD were found to have a significantly higher percentage of early losses and separations in their backgrounds. The figures ranged from 37% to 64% and were highly discriminating for BPD (Zanarini and Frankenburg 1997).

Early psychodynamic models seriously understated the role played by childhood trauma in the etiology and pathogenesis of BPD. There is now extensive empirical support for the notion that abuse during childhood is a major contributing factor to the etiology of the disorder (Baker et al. 1992; Gunderson and Sabo 1993; Herman et al. 1989; Ogata et al. 1990; Swartz et al. 1990; Walsh 1977; Westen et al. 1990; Zanarini et al. 1989b, 1997). Childhood sexual abuse appears to be an important etiological factor in around 60% of borderline patients. Although control patients with other personality disorders or depression do not report sexual abuse as often as do borderline patients, the same is not true for physical abuse, where the prevalence is roughly the same. About 25% of borderline patients have a history of parent–child incest. On the other hand, sexual abuse is neither necessary nor sufficient for the development of BPD, and other early experiences, such

as neglect by caretakers of both genders and chaotic or inconsistent home environments, also appear to be significant risk factors (Zanarini et al. 1997). This perspective was supported in a prospective study by Johnson et al. (1999) that linked borderline symptoms in adulthood to childhood sexual abuse and neglect but not to physical abuse.

Relatively few studies have sought to determine whether childhood maltreatment is specific to BPD or is part of the pathogenesis of all personality disorders. In the collaborative longitudinal personality disorder study (Battle et al. 2004), the investigators examined the childhood histories of 600 adults with personality disorder and reported three primary findings: 1) a large proportion of patients with personality disorder report exposure to neglect or abuse while growing up (73% disclosed prior abuse, and 82% reported childhood neglect); 2) when several personality disorder diagnoses were evaluated concurrently, the personality disorder diagnosis most associated with childhood mistreatment was BPD; and 3) two other personality disorder groups—obsessive-compulsive and antisocial—may also have elevated rates of mistreatment. Although this study has the disadvantage of being retrospective, it confirms the notion that childhood maltreatment plays a role in the development of BPD. However, the findings also demonstrate that not all individuals who develop BPD report these experiences of neglect and abuse in childhood.

Experiences of abuse and neglect are usually connected with problematic attachment patterns. Bateman and Fonagy (2004a, 2004b) developed a mentalization-based model derived from attachment theory. As discussed in Chapter 2, attachment theory posits four categories of child–caregiver bonds: 1) secure/autonomous, 2) insecure/dismissing, 3) preoccupied, and 4) unresolved/disorganized. Intimately related to these insecure modes of attachment is the defect in the ability to mentalize. Specifically, many borderline patients have a great deal of difficulty appreciating and recognizing that perceived states of oneself and others are fallible and subjective and are representations of reality that reflect only one of a range of possible perspectives. Mentalization is a feature of implicit procedural memory in that it is created in the context of secure attachment with a caregiver who ascribes mental states to the child, treats the child as someone with agency, and helps the child to create internal working models. In other words, one automatically reads the expression on another's face and knows what that person is feeling without extensive conscious effort to figure out the meaning of the facial expression.

In the absence of secure attachment, children have difficulty discerning their own mental states or those of others. A securely attached caregiver passes on this secure attachment and capacity to mentalize to the infant. Research has linked BPD patients with either preoccupied or unresolved/disor-

ganized categories of insecure attachment (Alexander et al. 1998; Allen 2001; Patrick et al. 1994; Stalker and Davies 1995). The failure to resolve trauma appears to distinguish the BPD group from others. Early childhood trauma leads to a defensive withdrawal from the mental world on the part of the victim. Hence some patients with BPD who have had severe trauma cope with the abuse by avoiding reflection on the content of the caregiver's mind, which prohibits resolution of abusive experiences (Fonagy 2001). One patient whose mother threatened to cut her hands off when she made a mess said that she stopped thinking about why her mother yelled at her because she was afraid her mother hated her and regarded her as a monster.

Fonagy et al. (1996) studied a sample of predominantly female inpatients with severe personality disorders. Using a Reflective Functioning Scale (Fonagy et al. 1997) that was developed to measure the capacity for mentalization, they were able to quantify this dimension. Of those with abuse and low reflective functioning, 97% met criteria for BPD. However, only 17% of the subjects in the group reporting abuse who were rated high in reflective functioning met criteria for BPD. Hence patients with mentalizing capacity could understand the caregiver's mind and process what happened so as to resolve the trauma. On the other hand, those who coped with abuse by refusing to think about what was going on in the caregiver's mind failed to mentalize and therefore could not resolve the abuse experience.

In normal development, mentalization is a psychological achievement. A child younger than the age of 3 operates primarily in the psychic equivalence mode (Fonagy 2001). In this mode the child assumes that perceptions of reality are identical to the reality itself. Somewhere around the age of 4 or 5, the child begins to integrate the pretend mode with the psychic equivalence mode of thinking. The 5- or 6-year-old child understands that one's perception is influenced by subjective factors. This allows for the phenomenon of play, where children can pretend to be someone other than who they are. Patients with BPD often have great difficulty shifting from the psychic equivalence mode to the pretend mode.

Self-organization is largely based on the capacity to conceive of oneself and others as mental agents (Bateman and Fonagy 2004a). In the course of development the child is under great pressure to somehow develop representation of internal states. Children typically find themselves in their mother's or caregiver's eye, as the parenting figure reflects back to them what he or she sees in the child. When parents or caregivers fail to provide this kind of experience, a frightening or frightened caregiver becomes internalized as part of the child's self structure (Fonagy and Target 2000). Hence a hostile or "alien" representation resides within the child's self representation. The child subsequently grows up with a need to externalize the alien self so that another mind is in control of these unpleasant attributes. This mechanism is

one explanation for why borderline patients repeatedly get into relationships in which they feel victimized by others who are experienced as persecuting. Through the process of projective identification, a patient may also influence a psychotherapist, for example, or any other significant figure to take on the characteristics of the "alien self" or "bad object."

A growing body of evidence suggests that there are strong neurological underpinnings in the etiology of BPD. A vulnerable, hyperreactive temperament is acted on by early experiences of trauma and/or neglect that create intense inner pain in the individual accompanied by difficulties in managing and expressing that pain (Zanarini and Frankenburg 2007). This combination appears to lead to intense difficulties with developing a stable sense of identity and chronic interpersonal dysfunction. Under the control of intense emotions there is dysregulation of both affect and cognition (Clarkin et al. 2007), and the borderline individual finds it difficult to integrate positive and negative views of the self and the other, leading to a fundamental split between segregated affects that are positive, on the one hand, and negative, on the other. This identity diffusion is paralleled in a splitting of objects into all-bad or all-good figures. The primary defenses are splitting and projective identification, by which the patient manages to separate the good from the bad and project the disavowed aspect into the therapist or a significant other in the patient's life (Clarkin et al. 2007a). As noted in great detail in Chapter 2, the borderline patient engaging in projective identification may assert intense interpersonal pressure on the other person to take on characteristics of the disavowed bad object.

The intensity of the rage in patients with BPD may obscure the underlying pain that accompanies the disorder. Research has shown that borderline patients experience a great deal of shame accompanied by a feeling of being acutely exposed and devalued (Rüsch et al. 2007). This proneness to shame is related to anger, high impulsivity, and low self-esteem.

Findings From Neurobiology

One consequence of early traumatic interactions with parents or caregivers is that borderline patients may have a persistent hypervigilance because they need to scan the environment for the possibility of others who may have malevolent intentions toward them. Neurobiological findings are confirming this sequela of developmental trauma. Rinne et al. (2002) studied 39 female BPD patients who were given combined dexamethasone/corticotropin-releasing hormone (CRH) tests, using 11 healthy subjects as controls. Twenty-four of these women had histories of sustained childhood abuse. Fifteen of them had no histories of sustained childhood abuse. When the au-

thors examined the results, the chronically abused BPD patients had significantly enhanced adrenocorticotropic hormone (ACTH) and cortisol responses to the dexamethasone/CRH challenge compared with nonabused subjects. They concluded that a history of sustained childhood abuse is associated with hyperresponsiveness of ACTH release. Their findings suggest that this hyperreactive physiological state is relevant to a subgroup of borderline patients but not to all. Sustained childhood abuse appears to increase the CRH receptors' sensitivity.

Knowledge of the hyperresponsiveness of the HPA (hypothalamic-pituitary-adrenal) axis fits well with our understanding of the pattern of internal object relationships in BPD. Because we understand that internal object relationships are created through building blocks of self representations, object representations, and affects linking the two, we can infer that an anxious and hypervigilant affect state would be linked to a perception of others as persecuting and of the self as victimized (Figure 15–1).

One function of the amygdala is to increase vigilance and to facilitate an individual's evaluation of the potential for novel or ambiguous situations (Donegan et al. 2003). A functional magnetic resonance imaging (fMRI) study (Herpertz et al. 2001) compared six female BPD patients with six female control subjects. The main finding of the study was that the amygdala on both sides of the borderline patients' brains showed enhanced activation compared with the amygdalas of the control group. The investigators concluded that the perceptual cortex in a borderline patient may be modulated through the amygdala, leading to increased attention to emotionally relevant environmental stimuli.

Two different studies (Donegan et al. 2003; Wagner and Linehan 1999) examined how borderline patients, compared with control subjects, react to standard presentations of faces. In one study (Donegan et al. 2003), borderline patients showed significantly greater left amygdala activation to facial expressions of emotion compared with control subjects. Of even greater importance, however, was the tendency for borderline subjects, in contrast with control subjects, to attribute negative attributes to neutral faces. Faces that were without expression were regarded as threatening, untrustworthy, and possibly plotting to do something nefarious. A hyperactive amygdala may be involved in the predisposition to be hypervigilant and overreactive to relatively benign emotional expressions. This misinterpretation of neutral facial expressions is clearly related to the transference misreadings that occur in psychotherapy of borderline patients.

The manner in which patients with BPD respond to facial expressions has much greater complexity to it than originally thought. Wagner and Linehan (1999) noted in their research that women who were diagnosed as BPD actually were *more* accurate in the labeling of fearful facial expressions than

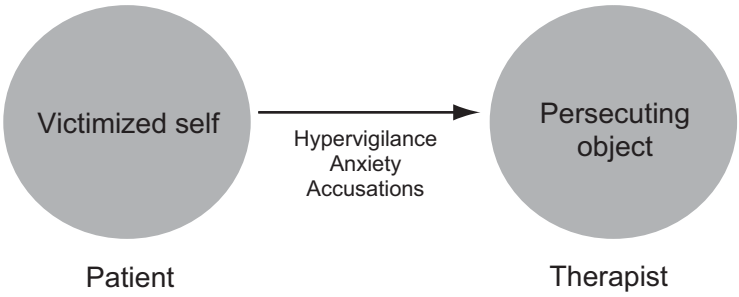

FIGURE 15–1. An internal object relationship associated with hyperreactivity of the HPA (hypothalamic-pituitary-adrenal) axis.

their non-BPD control subjects. Some observers have noted that patients with BPD have a kind of "radar" that allows them to read the face of the therapist in an extraordinarily accurate way, whereas others have emphasized distortions brought to bear by borderline patients. Lynch et al. (2006) studied 20 individuals with BPD and 20 controls using a "morphing" method. They used a technology such that faces changed gradually and monotonically from neutral expressions to prototypical emotional expressions of maximum intensity. This technology allowed them to evaluate both accuracy and how intense a facial expression had to be before accurate recognition occurred. Participants in the study who had BPD correctly identified facial affect at an earlier stage than did healthy controls. Moreover, the BPD participants were more sensitive than healthy controls in identifying the emotional expressions in general, regardless of their valence. Lynch et al. noted that heightened emotional sensitivity appeared to be a core feature of BPD and might possibly be related to the hyperreactive amygdalar response associated with trauma and the hyperreactive HPA axis. For patients who experience early childhood trauma, this hypervigilance may be adaptive and protective.

In a related study, Fertuck et al. (2009) compared 30 patients with BPD with 25 healthy controls using the Reading the Mind in the Eyes Test (RMET), developed by Baron-Cohen et al. (2001). This investigation found that the BPD group performed significantly better than the healthy controls on the test of reading facial expressions, particularly in the eyes. The investigators felt the enhanced performance is probably related to the greater threat potential perceived by BPD patients in facial stimuli and the hypervigilance alluded to above. Neutral faces may represent the most ambiguous threat, so there is particular vigilance paid to neutral facial expressions. The

BPD group in this study did particularly well compared with controls on faces of neutral emotional valence. This group of investigators stressed that the actual perception of facial expressions is fairly accurate in patients with BPD because of their need to assess moment-to-moment shifts in the emotional states of others for survival purposes. However, the problem area for BPD lies not in the perception of emotional expressions but in the *interpretation* of emotional expressions. The problem with misinterpretation is most striking in the neutral faces, where there is ambiguity. The difficulty appears to be assessing whether or not someone is trustworthy. BPD patients appear to have a good deal of difficulty in linking trustworthiness with facial expression and may overreact to minor signs of malevolence.

Studies using magnetic resonance imaging techniques with borderline patients and control subjects have demonstrated reduced hippocampal and amygdalar volumes in BPD patients versus control groups (Driessen et al. 2000; Schmahl et al. 2003a; van Elst et al. 2003). Although the role of trauma in reducing hippocampal volume has been established in many studies, the exact relationship between early trauma and the decreased volumes in the amygdala is unclear. In two studies (Lyoo et al. 1998; van Elst et al. 2003), reductions in frontal and orbitofrontal lobe volumes were also noted. These findings present a possible explanation. The weakening of prefrontal inhibitory controls may actually contribute to the hyperactivity of the amygdala (see Figure 15–2). Research using a specifically designed fMRI activation probe (Silbersweig et al. 2007) confirmed that under conditions associated with the interaction of behavioral inhibition and negative emotion, borderline patients showed relatively decreased ventromedial prefrontal activity compared with healthy subjects. In other words, the negative emotion generated in borderline patients and associated with amygdalar hyperreactivity is not sufficiently counteracted by the inhibitory function of the ventromedial prefrontal cortex, possibly resulting in the well-established problem that borderline patients have in calming down after they have become agitated.

Of particular interest in the fMRI study by van Elst et al. (2003) was that the left orbitofrontal volumes correlated significantly with amygdala volumes. The decrease in the volume of the hippocampus may be related to difficulties that borderline patients have in assessing how current relationships may or may not parallel past relationships and in learning from the experiences associated with those past relationships.

The centrality of separation anxiety and abandonment themes in patients with BPD has also been studied using positron emission tomography. Schmahl et al. (2003b) investigated brain blood flow in 20 women with a history of childhood sexual abuse while they listened to scripts describing neutral and personal abandonment events. Responses of the BPD patients

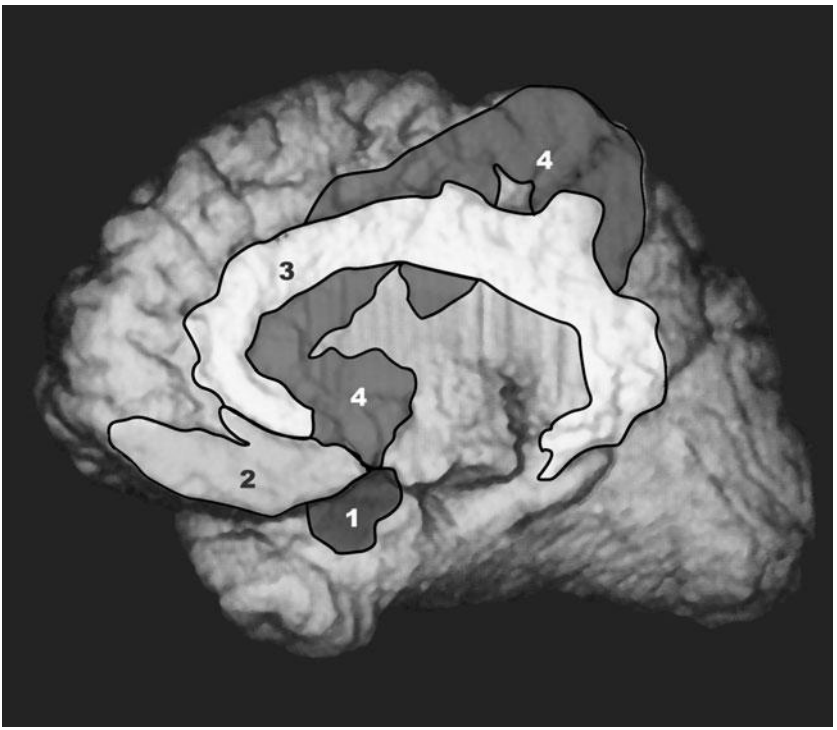

FIGURE 15–2. Proximity of the amygdala to prefrontal cortex.
Medial view of right hemisphere of brain is shown: 1: amygdala; 2: ventromedial (orbital) prefrontal cortex; 3: cingulate cortex; 4: somatosensory-related cortices.
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and those without BPD were compared. The findings implicated dysfunction of the medial and dorsolateral prefrontal cortex, including anterior cingulate, left temporal cortex, and visual association cortex in BPD patients. In the women with BPD, exposure to reminders of abandonment with personalized scripts resulted in increased activation in the same areas that have been documented in rhesus monkeys following separation from their mothers. Hence the investigators postulated that the stress associated with maternal separation activates the same brain region as memories of childhood abandonment in these patients. Because the medial prefrontal cortex has inhibitory connections to the amygdala and plays a role in extinction of fear responding, another possibility is that this pattern reflects an inability to shut down the generation of negative emotions from the amygdala.

Neural underpinnings of splitting have also been proposed. Early trauma may promote hemispheric lateralization and adversely affect integration of

the right and left hemispheres. Auditory probe–evoked potential attenuation was measured as an index of hemispheric activity in 10 subjects with a history of childhood trauma and 10 matched comparison subjects without such history while they recalled a neutral memory and then a traumatic memory (Schiffer et al. 1995). Abused children used their left hemisphere when thinking about neutral memories and the right hemisphere for frightening memories. The comparison group used both left and right sides equally, regardless of the memory content. This failure of hemispheric integration may be reflected in the use of splitting by BPD patients as a major defense mechanism.

Imaging studies suggest that mentalization involves several different brain structures working in concert (Baron-Cohen et al. 1999; Calarge et al. 2003; Frith and Frith 1999; Gallagher et al. 2000; Goel et al. 1995). Most of these studies involved asking the subject to perform mental activities that require an understanding of someone else's inner world. Calarge et al. (2003), for example, asked 13 healthy volunteers to place themselves in another person's place and attribute mental states to that person by having them describe the experience of a crying stranger met during a chance encounter on a park bench. The authors noted that these capacities are necessary in psychodynamic psychotherapy practice. As in other studies, the medial frontal region was activated when the subjects attributed mental states to others. One of the most significant findings was that the largest activation during the task occurred in the right cerebellum. Like Frith and Frith (1999), these investigators suggested that it is best to think of a "theory of mind" system or network that is widely distributed and made up of interactive nodes probably in the medial frontal regions, the superior temporal sulcus, the inferior frontal region, and the cerebellum.

The capacity to mentalize and recognize the inner state of another appears to be related to the trust problems encountered in patients who have BPD. Using neuroimaging techniques involving two simultaneous fMRIs, King-Casas et al. (2008) utilized a trust game to study the differences between patients with BPD and controls. In brief, two players were involved in an economic trust scheme. One was designated as the investor and invested money, while the other was designated as the trustee and paid money. Brain activity was measured in the anterior insula of the trustee during the game. This research found that patients with BPD tend to assume that no one is trustworthy, and therefore they expect everyone to be unfair. They lack the "gut feeling" that the relationship between investor and trustee is in jeopardy, and they failed to mentalize the other player's motivation and intent. The researchers concluded that BPD patients are impaired in their anterior insular activation; that is, they do not accurately and usefully evaluate a planned action by another person with negative consequences.

In addition to the other neurobiological features summarized here, an opioid deficit appears to play a role in borderline personality disorder. Prossin et al. (2010) compared patients with borderline personality disorder with a control group without the condition and found that there was a relative dysregulation of regional endogenous opioid function in the BPD patients. This hardwired opioid deficit may well be related to some of the clinical characteristics seen in BPD. For example, patients may be self-medicating when cutting themselves because they are releasing endogenous opioids. It is well established that opioids are involved in the regulation of emotions and that endogenous opioids facilitate normal social functioning in healthy individuals. It is quite possible that the hardwired deficits in endogenous opioids may be related to the almost universal social dysfunction observed in patients with BPD. New and Stanley (2010) note that BPD patients who take opiates report feeling euthymic rather than euphoric. Moreover, withdrawal is associated with sustained dysphoria. In light of the fact that the satisfaction accompanying intimacy with others throughout life, and even the early maternal attachment, seems to be a challenge for patients who have BPD, one can speculate that this difficulty could relate, at least in part, to insufficient endogenous opioids. Similarly, this deficit could be connected to difficulties in forming a therapeutic alliance. Emotional pain in BPD patients may be experienced as physical and unbearable, and it is this subjective experience that may be particularly difficult for psychotherapists who are treating these patients. The relative deficit in endogenous opioids may well play a role in this emotional pain.

Many of the neurobiological correlates of BPD appear to be trauma related, but some of these factors may be due to genetic, prenatal, or postnatal influences. Studies on etiology consistently find that histories of trauma and neglect are not present in all borderline patients. Hence any etiology must be thought of as multifactorial. Genetic data suggest that genetic factors are at work (Torgersen et al. 2000). Monozygotic twins showed a concordance rate of 35% for BPD, whereas dizygotic twins showed a concordance rate of only 7%.

Gunderson (2014) suggests that interpersonal hypersensitivity may be a genetically based temperament that is a common pathway for BPD. He notes that the core of BPD is the inability to control or contain emotion in the face of interpersonal events. He points out that negative interpersonal interactions predict suicide attempts, whereas positive interpersonal events precede remissions. The preborderline child tends to have a hypersensitivity that negatively affects early caretaking and activates an invalidating environment, predisposes the child to disorganized attachment, and leads to traumatic interpersonal stressors. This model also is compatible with recent research (Reichborn-Kjennerud et al. 2013) suggesting that most of the genetic effects

on the individual BPD criteria derive from one highly heritable general BPD factor, whereas environmental influences are more criterion-specific.

Further evidence of a biological substrate for BPD derives from data that suggest the presence of neurocognitive deficits. Andrulonis (1991) noted that significant numbers of borderline patients have soft signs of neurological difficulties, including a history of attention-deficit/hyperactivity disorder, learning problems, poor impulse control, and conduct disorder. Studies of neuropsychological impairments report that borderline patients have significantly more signs of such impairments but that some of the difficulties may be subtle and become evident only when BPD subjects are matched with healthy control subjects (O'Leary 2000; O'Leary and Cowdry 1994; Swirsky-Sacchetti et al. 1993; vanReekum et al. 1993). At least one study has also identified a significantly higher rate of head injury prior to diagnosis in BPD patients compared with control subjects (Streeter et al. 1995).

These accumulated data suggest that BPD has a multifactorial etiology. Zanarini and Frankenburg (1997) postulated three overarching factors. One is a traumatic and chaotic home environment, involving prolonged early separations, neglect, emotional discord in the family, insensitivity to the child's feelings and needs, and trauma of varying degrees. The second is a biologically based vulnerable temperament. The third factor relates to triggering events, such as attempting to form an intimate relationship, moving away from home, or experiencing a rape or other traumatic event, any of which may act as a catalyst to produce the symptomatology of the borderline condition. Certain types of genetically based temperaments may increase the likelihood that negative life events will occur, so there is an ongoing interactive effect of genes and environment in the development of BPD (Paris 1998). One conclusion is that each borderline patient may have a unique etiological pathway involving differing degrees of each of the etiological factors.

Treatment

Pharmacotherapy

Although the American Psychiatric Association's (2001) *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder* recommended both psychotherapy and medication, in the last decade, enthusiasm for medication has waned somewhat. No medication has been found to be uniformly or dramatically helpful (Gunderson 2014), and no drug is licensed by the U.S. Food and Drug Administration as an effective treatment for BPD. With some individuals, there appears to be benefit from certain medications, but for many others, no significant improvements are noted. The symptoms of BPD are so varied that they are frequently a formidable challenge for the

prescribing psychiatrist, and there are numerous examples in which the number of medications taken is inversely related to the improvement (Gunderson 2014). Psychiatrists must be cautious about overprescribing, and they must be wary of promising too much when medications are prescribed. Approximately 50% of patients with BPD will have comorbid major depressive disorder, and over a lifetime that figure goes up to 80% (Gunderson 2014). Often a solid alliance can be formed with the patient by explaining this comorbidity and emphasizing that the medication, probably an SSRI, will not cure the personality disorder but will target the depression.

There are several guidelines to consider when contemplating the use of medications with BPD patients: 1) collaborate with the patient on identifying target symptoms and recognizing side effects; 2) establish a policy that the medication will be tapered and another one will be tried if it is ineffective; 3) present medications with modest expectations and emphasize that the primary treatment is psychotherapeutic; 4) consider SSRIs if there are clear signs of a comorbid major depression or problems with impulsivity and anger; 5) if mood stabilizers must be used for depressed mood, impulsivity, and anger, topiramate and lamotrigine are safer than lithium (Gunderson 2014); 6) atypical antipsychotics may be useful for anger and impulse control but run the risk of causing serious weight gain and inducing the metabolic syndrome, so they should be avoided if possible; if their use is absolutely necessary, consider time-limited usage followed by tapering off the medication when the patient is more stable; and 7) be wary of using benzodiazepines because they can sedate the patient and result in behavioral disinhibition.

One must also be aware that there may be a high probability with patients who have BPD to decide to increase or decrease the dosage depending on how they feel in the course of a day. Hence, one must establish an alliance as well on the issue of changing or discontinuing medications such that the patient feels he or she can call the psychiatrist and collaboratively discuss the need for increase or decrease in dosage rather than simply acting on it. When patients refuse medication, it is best not to attempt to force the issue. Rather, a thoughtful and open-minded discussion of the pros and cons of medication is the most useful way to proceed. Often, when the patient does not feel pressure by the psychiatrist, he or she is much more willing to undergo a trial of a pharmacotherapeutic agent.

Psychotherapeutic Approaches

Empirical Research

Clinicians have long known that borderline personality disorder can be helped with psychotherapy. Now that clinical impression has been bolstered by a substantial body of empirical research. At least seven forms of psychotherapy have

been demonstrated to have efficacy in randomized controlled trials: mentalization-based therapy (MBT; Bateman and Fonagy 2009), transference-focused therapy (TFP; Clarkin et al. 2007b), dialectical behavior therapy (DBT; Linehan 2006), schema-focused therapy (Giesen-Bloo et al. 2006), Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum et al. 2008), general psychiatric management (GPM; McMain et al. 2012), and dynamic deconstructive psychotherapy (DDP; Gregory et al. 2010).

When one reviews the research findings on psychotherapy for BPD, one might easily reach the conclusion that "everything works." How can we understand that psychotherapies based on diverse theoretical models all seem to result in improvement of the patient? There are several possible explanations that should be considered (Gabbard 2010):

1. All therapeutic approaches provide a systematic conceptual framework of pathogenesis and treatment that allows the patient to organize his or her internal chaos and make sense out of it.
2. Different types of patients with BPD respond to different elements of the therapeutic action. For example, some patients may use transference interpretation, whereas others may destabilize with it, so they cannot process ideas offered to them. Studies using group mean values for outcome can lead to a "washout effect" as those who benefit cancel out those who do worse (Gabbard and Horowitz 2009).
3. The therapeutic alliance may be the key factor in change. As noted in Chapter 4, the therapeutic relationship is generally regarded as the best predictor of outcome regardless of the theoretical orientation of the treatment.
4. All of the disparate approaches may act through similar underlying neurophysiological processes. As noted in the section "Findings From Neurobiology," research suggests that amygdalar hyperreactivity is common in BPD and is accompanied by decreased activity in the prefrontal cortex. It may be that effective therapeutic modalities are increasing the activity of the prefrontal cortex, resulting in a more effective regulation of the amygdala. In other words, the therapeutic relationship is used to sharpen the patient's self-observational capacity for reappraising assumptions and perceptions that are automatic and reflexive.

Although these questions are currently unanswerable, we can certainly find encouragement in the recurrent finding that BPD is a treatable condition that responds to a systematic psychotherapeutic approach. Because this textbook is focused on psychodynamic psychiatry, we will limit ourselves to consideration of the four psychodynamic approaches in the list of seven efficacious psychotherapies.

The cornerstone of MBT is enhancement of mentalization. A major goal is to stabilize the sense of self, recognizing that a lack of secure attachment in childhood made it difficult for these patients to find themselves in the eyes of their caregivers or parents. When borderline patients begin therapy, they may attack the therapist, but this should be viewed as a gesture of hope—a desperate wish for a new beginning and a fervent desire for the therapist to handle the intolerable aspects of the self that seem unmanageable to the patient. Relationships are absolutely necessary to stabilize the self structure by externalizing the "alien self" into the therapist. In this regard, Bateman and Fonagy (2004a) stated, "Borderline patients require rather than enjoy relationships" (p. 41). Their model consists of combined individual and group psychotherapy.

Several core techniques are critical to this approach. Therapists must retain in their own minds a clear and coherent image of their role as therapist and maintain a mentalizing stance. In this position therapists allow themselves to be drawn into the internal world of the patient by accepting what is projected into them but also maintaining a clear and coherent image of one's own state of mind observing the process. Another critical ingredient to enhance mentalization is to demonstrate the possibility of multiple perspectives on the self and others whenever possible. In mentalization-based therapy, therapists attempt to represent the current or immediately passed feeling state of the patient along with its accompanying internal representations (Bateman and Fonagy 2004a). The emphasis is on current relationships and the patient's wishes, beliefs, and feelings to help familiarize patients with their internal world. Reconstruction in the transference is deemphasized, and transference distortion is used primarily as demonstrating alternative perspectives between therapist and patient. The approach to transference is slow and gradual, based on the patient's level of anxiety. Much of the therapist's focus is on simple interpretations that show how he or she believes the patient is experiencing the therapist. Bateman and Fonagy view the *process* of interpreting as more important than the *content* because that helps patients see that they are in the therapist's mind.

An 18-month MBT approach in an outpatient context was tested against a control treatment that involved outpatient structured clinical management by Bateman and Fonagy (2009). Substantial improvements were shown in both conditions across all outcome variables. Although self-harm improved more slowly with MBT than with the control management approach, interpersonal measures, social adjustment, mood, and need for hospitalization changed more rapidly and more extensively with MBT.

TFP is based on Kernberg's conceptualization of borderline personality organization (Clarkin et al. 2007b). As with the Bateman and Fonagy approach, mental representations are viewed as derived from the internalization

of attachment relationships with caregivers and reexperienced with the therapist. Key components of the model involve identity diffusion; problems with negative affect, especially hostility and aggression; and poor self-regulation manifested by impulsive behaviors. The technique relies principally on clarification, confrontation, and interpretation within the evolving transference relationship between the patient and the therapist. The individual therapy sessions take place twice per week and have a more tightly structured treatment frame based on an initial treatment contract and clear treatment priorities. In contrast to mentalization-based therapy, there is early focus on transference, especially negative transference. Medication is prescribed according to the needs of the patient. Weekly group supervision *is* part of the approach just as it is in mentalization-based therapy.

TFP was compared with supportive therapy and DBT in a randomized controlled trial involving the three treatments (Clarkin et al. 2007b). Ninety patients with BPD were randomized to one of the three manualized treatments (Clarkin et al. 2004). All three groups showed similar levels of improvement, but the TFP patients showed greater increase in mentalization as measured by reflective functioning and movement in the direction of more secure attachment.

DDP is a relatively new treatment compared with the others discussed in this chapter. Nevertheless, it has been demonstrated to be efficacious in a 12-month controlled trial in which patients with BPD and co-occurring alcohol use disorders were randomized to either DDP or optimized community care. Following 12 months of active treatment with DDP, they were then reevaluated after an additional 18 months of naturalistic care in the community. DDP demonstrated between-group treatment effects for the core symptoms of BPD, depression, suicide behavior, alcohol misuse, recreational drug use, need for inpatient care, and perceived social support (Gregory et al. 2010).

DDP is based on object relations theory, recent developments in neuroscience, and deconstructionist philosophy. Therapists provide weekly 1-hour individual sessions that are focused on recent episodes of interpersonal encounters and maladaptive behavior by identifying and differentiating specific emotions associated with these episodes. The therapist helps the patient integrate different ways of making meaning out of these episodes. Therapists also provide novel experiences in the therapist-patient relationship to help patients challenge basic assumptions about themselves and others.

Taken together, these studies illustrate that although there is no "quick fix" for BPD, those patients who stay in dynamic therapy for a substantial period of time may experience significant improvement. Moreover, these studies also demonstrate that financial support for extended weekly psychotherapy may be cost-effective in the long run. Borderline patients, by their

very nature, are treatment seeking, and if denied access to psychotherapy, they will incur increased costs by appearing in emergency departments with overdoses that require intensive care or psychiatric hospitalization, by visiting other medical practitioners, and by running up so-called indirect costs from extensive work disability (Gabbard 1997). Bateman and Fonagy (2003) examined health service utilization costs for the borderline patients treated in their Halliwick Day Unit program and compared it with general psychiatric care. They found that the psychoanalytically oriented partial hospitalization costs were offset by less psychiatric inpatient care and reduced emergency department treatment. After discharge, the average annual cost of monitored health care for the treatment group was one-fifth of that for the general psychiatric care group.

The fourth psychodynamically based treatment is GPM. This form of treatment was tested in a large multisite randomized controlled trial (McMain et al. 2009), in which it was shown to result in the same clinical efficacy as DBT. It was based on the book *Borderline Personality Disorder: A Clinical Guide* (Gunderson and Links 2008). In essence, it is a treatment involving psychodynamically informed case management that draws heavily from Winnicott's notion of "holding environment" and "good enough parenting" (Winnicot 1953). Gunderson (2014) has subsequently developed this approach into a handbook that is designed to make effective treatment available to a larger group of patients. Indeed, Gunderson's slight modification of the branding of the treatment to "good psychiatric management" is designed to convey that the treatment is "good enough for most borderline patients." It is not designed to compete with the evidence-based therapies done by professionals who have career interests in being experts on the treatment of BPD. This approach is structured such that mental health professionals with less experience and expertise can still provide competent treatment that allows more patients with BPD to have effective, psychodynamically informed treatment. The distinctive characteristics of the approach are the following: 1) case management focuses on the patient's life outside of therapy on the basis of the notion that interpersonal hypersensitivity must be one of the main targets of the treatment; 2) psychoeducation informs patients and families about the genetic or temperamental characteristics of BPD, the expectable changes, and the different approaches to treatment; 3) goals that involve symptom reduction and self-control are considered secondary to attaining the primary goals of success and work in partnerships; 4) multimodal strategies include medication as needed, as well as group therapy and/or family coaching; and 5) no specific duration or frequency of treatment is prescribed, but the therapist and patient collaborate on judging whether a therapy is effective. Although GPM may differ from the more rigorous empirically validated therapies, it is noteworthy that the out-

comes are roughly the same as those that are obtained from the competing approaches.

Expressive Versus Supportive Approaches

Although individual psychodynamic therapy for patients with BPD is effective, virtually all clinicians would agree that it is at times extraordinarily challenging and emotionally taxing for the therapist. It is important to emphasize that the empirically validated treatments all incorporate some form of group or individual supervision. Hence, clinicians who are treating borderline patients are well advised to consult regularly with a respected and knowledgeable colleague to ensure that the countertransference blind spots are not giving rise to unexpected difficulties in the form of rescue fantasies or enactments of anger or frustration. A major problem in the psychotherapy of borderline individuals is the tenuous nature of the therapeutic alliance (Adler 1979; Gabbard et al. 1988, 1994; Gorney 1979; Horwitz et al. 1996; Kernberg 1976; Masterson 1976; Modell 1976; Zetzel 1971). These patients have difficulty viewing their therapist as a helpful figure who is working collaboratively with them toward mutually perceived goals.

Much of the controversy in the literature regarding the relative value of expressive versus supportive interventions revolves around which approach is more likely to foster the development and maintenance of the therapeutic alliance. Without a rudimentary therapeutic alliance, the therapist may not have a patient.

This controversy over the relative merits of expressive and supportive interventions is reflected in the contradictory findings of The Menninger Foundation Psychotherapy Research Project. The project's quantitative study (Kernberg et al. 1972) revealed that borderline patients treated by skilled therapists who focused intently on the transference showed a significantly better outcome than did those treated by skilled therapists who focused less on the transference. In contrast, the prediction study of the project (Horwitz 1974), using both quantitative and qualitative assessments of the treatment process, suggested that a series of patients, some of whom were borderline and were treated by predominantly supportive methods, showed greater gains in supportive treatment than anticipated. As reported in Chapter 4, Wallerstein's (1986) examination of the data from this project suggested that all treatments were characterized by a mixture of expressive and supportive interventions. These apparently contradictory findings with regard to transference focus remain unresolved, in part because the original design of the study had several shortcomings relevant to this issue: 1) the specific diagnostic category of BPD was not used; 2) a detailed process study was not undertaken, so that essential treatment developments could only be

roughly approximated at the termination of treatment; and 3) the therapeutic alliance was not one of the project's variables. Retrospectively, however, the prediction study found the therapeutic alliance useful in conceptualizing results (Horwitz 1974).

Both expressive and supportive approaches are useful for *some* patients at *some* points in the treatment (Gabbard et al. 1994; Horwitz et al. 1996). We are dealing with a spectrum of highly heterogeneous patients who require individually tailored psychotherapeutic approaches (Meissner 1988). To a large extent, the same indications for expressive or supportive emphasis (see Table 4–1 in Chapter 4) that guide the clinician's work with other diagnostic entities apply to psychotherapy with borderline patients.

Because of these concerns, The Menninger Clinic Treatment Interventions Project studied the detailed process of representative sessions from three cases of long-term dynamic therapy of borderline patients at The Menninger Clinic (Gabbard et al. 1988, 1994; Horwitz et al. 1996). All sessions of the three psychotherapy processes were audiotaped, and two sets of investigators worked from typed transcripts of randomly selected psychotherapy hours. A team of three clinician-researchers rated the interventions on the basis of their degree of expressiveness or supportiveness. As described in Chapter 4, from the expressive end of the continuum to the supportive end, the interventions were rated as follows: interpretation, confrontation, clarification, encouragement to elaborate, empathic validation, advice and praise, and affirmation. Each of these seven interventions was also classified as having a focus on either transference or extratransference issues. A separate team of three clinical judges assessed the patient's collaboration with the therapist as a measure of the therapeutic alliance. The judges were primarily interested in detecting upward or downward shifts in the patient's collaboration, as measured by the patient's bringing in significant content or making productive use of the therapist's contributions. We were particularly interested in determining whether the shifts could be related to the therapist's interventions.

One of the conclusions reached was that transference interpretations are a "high-risk, high-gain" intervention in the dynamic psychotherapy of borderline patients (Gabbard et al. 1994). They tend to have greater impact—both positive and negative—than other interventions made with such patients. Whereas in some cases they resulted in substantial improvement in the patient's ability to collaborate with the therapist, in others they led to marked deterioration in that collaboration.

In our efforts to determine which transference interpretations increased collaboration and which resulted in deterioration in the therapeutic alliance, we found several key factors at work. First, paving the way for transference interpretation with affirmative appreciation of the patient's internal experi-

ence may be of crucial importance. Surgeons need anesthesia before they can operate. The psychotherapist needs to create a holding environment through empathic validation of the patient's experience before offering an interpretation of unconscious dynamics. Expressive and supportive approaches are often artificially polarized, when in actuality the two work synergistically in most psychotherapeutic situations.

Gunderson has stressed the importance of recognizing the reality of early trauma in the form of child abuse in many borderline patients (Gunderson and Chu 1993; Gunderson and Sabo 1993). They observed that therapists may be able to forge a stronger therapeutic alliance by validating and acknowledging the effects of early trauma on the patient's capacity to form trusting relationships as an adult.

The tendency to force transference interpretations on unprepared patients who are oriented toward externalization and action rather than reflection may result from the inherent bias of many analysts and dynamic therapists toward expressive rather than supportive strategies. Gunderson (1992) candidly reflected on his own tendency to push patients to engage in transference work while insufficiently acknowledging that their functioning outside the therapy has improved dramatically. He recognized that he occasionally made the error of becoming preoccupied with the patient's failure to collaborate in self-examination rather than actively supporting the patient's substantial improvement in functioning.

Although the therapeutic approach varies depending on the needs of the patient, several principles of technique apply rather broadly to most patients with the borderline diagnosis. These suggestions derive both from implications of the neurobiological findings and from the randomized trials reported.

Maintain flexibility. A flexible therapeutic stance is necessary for the optimal treatment of patients with BPD. As a general rule, higher-level borderline patients with greater ego strengths and greater psychological mindedness will be more able to use expressively oriented psychotherapy than those closer to the psychotic border, who will need a supportive emphasis. Most will require a flexible stance on the part of the therapist, with shifts between interpretive and noninterpretive interventions geared to the state of the patient's relatedness to the therapist at a given moment. No single theory is likely to insulate the therapist from the tumultuous emotional affects experienced by both partners of the dyad. Most therapists find themselves using a trial-and-error approach until they can clearly determine which interventions are most effective with a given patient.

Because of well-founded concerns about the potential to transgress boundaries with borderline patients (Gabbard 2003; Gabbard and Wilkin-

son 1994; Gutheil 1989), the beginning therapist may take an unyielding position that is experienced by the patient as remote and cold. The patient may then quit the therapy because of the therapist's apparent lack of responsiveness. The therapist needs to strive for a disciplined spontaneity in which professional boundaries and focus are maintained—but in the context of an acknowledged human interaction involving two people struggling to get to know one another. It is useful to think of the character dimension of the borderline patient as involving an ongoing attempt to actualize certain patterns of internal object relations in a current relationship (Gabbard 1998; Sandler 1981). Through his or her behavior, the patient subtly attempts to impose a certain way of responding and experiencing on others. Therapists need to allow themselves sufficient flexibility to respond spontaneously to the form of object relatedness that is being thrust upon them. In other words, the therapist joins in a "dance" based on specific music within the patient that provides a wealth of information about the patient's characteristic difficulties in human relationships outside the transference-countertransference situation. This response must be attenuated and partial, of course, and the therapist must attempt to maintain a reflective stance regarding the "dance."

Establish conditions that make psychotherapy viable. Because of the chaotic nature of the borderline patient's life, stability must be imposed from external sources early in the process. In the pretherapy consultations and throughout the course of the therapy, the psychotherapist must establish and reestablish what therapy involves and how it differs from other relationships. Among the topics that should be covered are clear expectations about fee payment, consistent appointment times, the need to end sessions on time even though the patient may wish to stay longer, and an explicit policy about the consequences of missed appointments. In addition, with a suicidal borderline patient, the therapist may wish to make it clear that in a situation of acute suicide risk, it is impossible for the therapist to prevent the patient from acting on his or her impulses, and hospitalization may be needed. In a substance-abusing patient, the therapist may need to insist that the patient attend a 12-step program as a condition of the treatment. When medication is obviously indicated, the therapist may need to make clear that the patient's willingness to try medication is an essential component of the overall treatment plan. Besides establishing the conditions that will make psychotherapy viable, the therapist is also communicating his or her own limits to the patient. This communication often is at odds with the patient's expectations that the therapist will be an omnipotent rescuer. Hence, this dialogue leads directly into a discussion of what therapy is and what it is not.

In the pretherapy phase of consultations, the TFP approach establishes a "contract" with the patient (Clarkin et al. 2007b; Kernberg et al. 1989). As

part of setting up this contract, the therapist makes clear that it is not within the psychotherapist's role to get involved in the actions of the patient's life outside of the sessions. Hence, the therapist does not expect to receive phone calls between sessions and makes it clear that his or her availability is quite limited. However, this approach may interfere with the development of a stable attachment to the therapist, especially if the conditions of the "contract" seem impossible for the patient. As Gunderson (1996, 2001) pointed out, the patient may have recurrent reactions of panic because of poorly developed evocative memory and may need to call the therapist periodically to develop a stable representation that can be internalized. Gunderson suggested that the therapist should discuss between-session availability only *after* the patient initiates an inquiry about it. He suggested, and I concur, that patients be told that the therapist wishes to be contacted in an emergency. This position avoids an adversarial beginning to the process and often makes the patient feel understood and "held" in the sense intended by Winnicott. If phone calls do occur between sessions, Gunderson recommended that the calls be the focus of exploration in the therapeutic work. As the therapist comes to recognize the patient's fear of aloneness and its developmental meaning, the patient's development of holding-soothing introjects—as described by Adler (1979, 1985)—may be facilitated. If the phone calls become excessive, clear limits can be imposed while also exploring the meaning and significance of the between-session contacts.

Avoid a passive stance. Psychodynamic therapy is sometimes mischaracterized as nondirective, but the reality is that a good dynamic therapist frequently directs the patient's attention to issues that are being defensively avoided. Neurobiological findings suggest that the prefrontal cortex needs to be engaged to process and regulate intense feelings arising from amygdalar hyperreactivity. A key principle that the therapist must make clear to the patient is that *therapeutic change takes effort*. Too many therapists may allow patients to ramble through the entire therapy session, venting about what has happened recently without taking time to think and reflect about the significance of the event that they are describing. The therapist must help the patient think through the factors that triggered the emotional response and the consequences in terms of interpersonal relationships. Therefore, the psychotherapist needs to be forthright in interrupting the patient at times and asking the patient to reflect about the significance of what is being described. From the standpoint of neurobiology, the therapist is directing mental resources away from lower-level limbic responses and toward higher-level prefrontal functions (Gabbard 2012).

The empirically supported psychotherapies for BPD all feature some variant of self-reflective or mindfulness-promoting techniques that facilitate

this processing. Using functional imaging techniques, Ochsner et al. (2002) have shown that actively rethinking or reappraising feelings causes prefrontal activation that modulates limbic-based negative feelings such as fear.

Allow transformation into the bad object. One of the most difficult challenges in the psychotherapy of borderline patients is to tolerate and contain the patient's intense anger, aggression, and hate. Therapists often feel falsely accused, and an inner voice wants to ask the patient, "How can you possibly accuse me of being worthless when I'm trying so hard to help you?" It is helpful to remember that these patients struggle with intense anger related to a constitutional temperament that is hypersensitive and hyperreactive to relatively small triggers and that they have a lifelong history of struggling with others who have enraged them. In some cases they have experienced abusive treatment from others, while in other cases they have interpreted in a highly subjective and idiosyncratic way that someone has malevolent intentions toward them that may not accurately represent the other's intention. Borderline patients are searching for a "bad-enough object" (Rosen 1993). In a paradoxical way, patients find it predictable, familiar, and even soothing to re-create an angry, conflictual internal object relationship from childhood with the therapist. When the therapist resists this transformation, patients may have to escalate their provocativeness and work even harder to transform the therapist (Fonagy 1998). Bateman and Fonagy (2004a, 2004b) would describe this transformation as an acceptance of the patient's need to externalize the "alien self."

Therapists who defend against the growing aggression within them may strive to be more and more saintly in response to patients' verbal attacks. They may also make transference interpretations that attempt to force the patient to take back his or her hostility rather than project it into the therapist. Alternatively, the therapist may subtly withdraw from an emotional investment in the patient, consciously or unconsciously hoping that the patient will quit therapy and find someone else to torment. Another, more disconcerting alternative is that the therapist may begin to make hostile or sarcastic comments or even explode in anger at the patient. Allowing the transformation into the bad object does not mean that the therapist loses any sense of professional decorum. Rather, it requires that the therapist function as a container who accepts the projections and attempts to understand them and hold them for the patient until the patient is once again able to own these projected aspects for him- or herself, much as was described in Chapter 14 in dealing with paranoid patients. As I have noted elsewhere (Gabbard and Wilkinson 1994), "The optimal state of mind for therapists is when they can allow themselves to be 'sucked in' to the patient's world while retaining the ability to observe it happening in front of their eyes. In such a state, ther-

apists are truly thinking their own thoughts, even though they are under the patient's influence to some extent" (p. 82).

Many instances of mismanagement of suicide threats relate to a countertransference wish to avoid being the bad object (Gabbard 2003). Borderline patients often suggest to the therapist that they will be driven to suicide because of the therapist's insufficiencies (Maltsberger 1999). These accusations fuel therapists' doubts and activate their own abandonment anxiety, so therapists in this situation may attempt to demonstrate their caring through heroic measures to try to save the patient, a countertransference response I have referred to as "disidentification with the aggressor" (Gabbard 2003). The result may be that the patient exercises an omnipotent control over the therapist—what Maltsberger (1999) has called *coercive bondage*. In this scenario, the therapist takes full responsibility for the patient's survival instead of allowing the patient to accept most of the responsibility for his or her own living or dying, which is imperative if the patient is to ultimately get better.

Empathize with the pain beneath the anger. Many clinicians have been taken aback by the intensity of the anger that is expressed or enacted by a borderline patient, especially after he or she feels he or she has been slighted. If one responds to the anger by taking it at face value, there is the potential for an escalating conflict to occur between therapist and patient. One must remember that the eruption results from deep narcissistic wounds in the patient. It may arise as well from the patient's sense that he or she is about to be abandoned or is not worthy of the therapist's attention. Hence, one key to the success of treating borderline patients is to get beyond the rage and attune oneself to the underlying pain. There appears to be an opioid deficit in patients with this diagnosis that has made intimacy with others and interpersonal trust a challenge throughout their lives. It is helpful for therapists to remember that emotional pain in a person with borderline personality disorder may be experienced as physical or unbearable because of this deficiency in the endogenously occurring opioids that in others may come to the rescue with a chemical form of soothing.

One primary task of the therapist is to contain the pain and anger of the patient, knowing that it may take two minds to think one's most emotionally distressing thoughts and experience one's most painful feelings (Bion 1987). The aim of the treatment is to help patients develop their own capacity for thinking and override the intensity of the affect and the pain. In Bion's terms the therapist takes the patient's beta elements, which are sensory impressions related to emotional experience, and uses his or her own alpha function to transform these beta elements into thinkable thoughts. Hence, just as the prefrontal cortex must be harnessed to think about the amygdalar storm and its origins, thinking must be brought to bear to manage unbearable emo-

tional pain. Although the opiate deficit contributes to the feeling that the pain is not bearable in the patient, from a conceptual perspective it may help the therapist to avoid blaming the patient by recognizing the biologically based deficit state in the patient. Therapists thus facilitate hope by illustrating that painful affect states are tolerable and can be survived. The therapist takes a position of calm refusal to accept the terms offered by the patient and tries to continue thinking while feeling colonized by the patient's affect.

Promote mentalization. One of the greatest challenges in the psychotherapy of borderline patients is dealing with transference perceptions that are locked into a psychic equivalence mode in which patients view their perceptions of reality as absolute fact rather than one of several possibilities based on internal factors.

> A 28-year-old patient had been in therapy for 6 months when an apparently minor event in a therapy session triggered a major reaction. With about 5 minutes left in the session, she began talking about having visited her family during the Thanksgiving holidays. She said she felt unimportant to her father because he seemed much more interested in her brother's activities than in hers. In the course of this discussion, the therapist looked at the clock on the wall because he knew the time was running out and he wanted to see if he had time to make an observation about her assumption regarding her father's feelings about her. The patient stopped talking and looked at the floor. The therapist asked what was wrong. After a few moments of silence, she burst into tears and said, "You can't wait for me to get out of your office! I'm sorry if I'm boring you! I've known for a long time that you can't stand me, and you just do this for the money. I'll leave now if you want me to."
>
> The therapist was taken aback and replied, somewhat defensively, that he was simply monitoring the time because he wanted to be sure he had time to say something before the session was over. The patient replied by saying, "Nice try to get out of it. You think I'm going to believe that?" The therapist, escalating in his defensiveness, stated emphatically, "Whether you believe it or not, that's the truth." The patient was adamant: "I saw what I saw." She placed her hand firmly on the wooden table next to her chair, and she raised her voice: "It's like you're telling me that this table is not made out of wood!" Feeling as misunderstood as the patient, the therapist continued: "All I'm saying is this: it's possible that I looked at the clock for reasons other than the ones you attribute to me. Just like you may make assumptions about your dad." The patient became even more insistent in response to the therapist's efforts to offer other possibilities: "Now you're trying to say I didn't see what I saw! At least you could admit it!"

In this vignette the psychotherapist is struggling to manage the almost delusional conviction of this particular patient that her perception is a direct reflection of reality rather than a representation of reality based on internal feelings, beliefs, and past experiences. This failure to mentalize, character-

ized by the psychic equivalence mode, may make it extremely difficult to work on transference issues. Patients in this mode of functioning are convinced that their view of the therapist is "correct" because they are incapable of "playing" in the transference; they are not able to enter the pretend mode and reflect on the internal world of themselves and others.

In this vignette the patient becomes terrorized and cannot think or reflect because of the reexperiencing of past trauma-based internal object relationships. Note also how the intensity of the patient's accusation erodes the therapist's capacity to think so that he escalates his defensiveness to the point where he actually became a version of the persecuting object that she feared. This projective identification process, in which the therapist is coerced into playing a role in the patient's internal drama, can cause therapists to temporarily to lose their own capacity for mentalization under pressure from the patient (Gabbard 2010). In other words, the therapist was insisting that only his own version of reality was valid. Borderline patients thus may colonize the minds of the therapists as a way of extruding and controlling perceived danger from within. The therapist clearly became the bad persecuting object.

The patient's almost delusional conviction can make therapists begin to doubt themselves. Promoting mentalization under such circumstances can be extraordinarily challenging. As noted previously, interpreting the meaning of enactments may be premature for patients who are unable to mentalize. It may be much more useful to help such patients elaborate on the emotional state that may have triggered the enactment (Fonagy 1998). For example, a patient came to therapy saying that she had binged on 10 candy bars the previous evening. The therapist asked her to elaborate on what had triggered the binge. Although she initially said that she did not know, as the therapist continued to gently press for possible precipitating factors and emotional states, the patient eventually recalled that a man she had met had called her to ask her out on a date. She then said that if she had gone out to dinner with him, he would have undoubtedly regarded her as "fat pig" and never asked her out again. So she hung up the phone and then went to the store to buy candy bars. Through this encouragement to understand the emotional state that precipitated the enactment, the therapist also helped to establish a connection between feelings and actions. In other words, the bingeing did not come out of the blue. Rather, it emerged from feelings of self-loathing and anxiety related to the invitation to dinner from the man she had met.

Another way to promote mentalization is to observe the patient's moment-to-moment changes in feelings so that the patient can eventually internalize the therapist's observations of his or her internal state. In addition, it is useful to encourage the patient's fantasy about the therapist's internal state (i.e., in the broadest sense, the therapist's countertransference). Hence, Gunderson

(1996) suggested that when called in the middle of the night, the therapist may explore the patient's fantasy in the next session by asking, "How did you think I would feel about your call?" Another technique to encourage more reflectiveness is to help the patient think about the consequences of self-destructive behaviors (Waldinger 1987). Many of the self-destructive behaviors of borderline patients are enacted in the urgency of the moment without any consideration of the eventual consequences of these acts. Through repeated questioning about the potential adverse consequences of such behaviors, the therapist may help them become less gratifying to the patient.

Set limits when necessary. Many borderline patients experience the usual professional boundaries as cruel and punitive deprivation by the therapist. They may demand more concrete demonstrations of caring, such as hugs, extended sessions, decreases in the fee, and round-the-clock availability (Gabbard and Wilkinson 1994). Some therapists who experience guilt feelings about the setting of limits may begin to cross professional boundaries with borderline patients in the name of flexibility or suicide prevention (Gabbard 1989c; Gutheil 1989). One male therapist, for example, began seeing a female patient twice a week for psychotherapy, but within a year was seeing the patient seven times a week. On Sundays, he would make a special trip to his office just to see this patient. When a consultant questioned this behavior, the therapist defended it as necessary to prevent the patient from committing suicide. He also acknowledged that he allowed the patient to sit on his lap during their sessions, justifying this behavior as a way to provide the patient with the mothering that she had not received as a child.

Some therapists feel that they are being cruel and sadistic when enforcing reasonable limits on the patient's enactments. Paradoxically, however, many patients who demand greater freedom get worse when it is granted to them. In a spin-off study of The Menninger Foundation Psychotherapy Research Project, Colson et al. (1985) examined the cases with negative outcomes. One common denominator was the therapist's failure to set limits on acting-out behaviors. Instead, the therapist would simply continue to interpret the unconscious motivations for the acting-out while the patient's condition deteriorated.

In a succinct summary of the group of behaviors that require limit setting, Waldinger (1987) identified those that threaten the safety of the therapist or the patient and those that jeopardize the psychotherapy itself. Suicide is an ever-present risk with borderline patients, and therapists must be ready to hospitalize their patients when these impulses become overwhelming. Therapists often find themselves in the untenable position of heroically attempting to treat lethal patients by having continuous contact with

them. One therapist ended up talking on the phone to a borderline patient for an hour every night to prevent her from killing herself.

Help the patient re-own aspects of the self that have been disavowed or projected onto others. Because splitting and projective identification are primary defense mechanisms of patients with BPD, an experience of being incomplete or fragmented is a core phenomenon in borderline psychopathology. Patients in psychotherapy often use a form of *temporal splitting,* in which they disown behavior or comments that occurred a week ago or a month ago, almost as if someone else were responsible. A therapist might ask why the patient exploded in the last session, and the patient may be perplexed that the therapist even brought up the outburst. The patient may say in response, "I don't know why you are bringing that up now. I don't feel that way anymore." This lack of self-continuity also emerges in the form of dramatic changes from week to week in how these patients present themselves to the therapist. The therapist's task is to connect these fragmented aspects of the patient's self and interpret the underlying anxieties connected with re-owning and integrating the disparate self representations into a coherent whole. Similarly, the patient's internal self and object representations are projected onto the therapist or other individuals. Over time, therapists attempt to help borderline patients understand that they are unconsciously placing aspects of themselves in others as a way of attempting to control those distressing parts of themselves. Much of this effort involves interpretation of patients' fears that if they integrate the good and the bad aspects of themselves and others, the intense hatred they harbor will destroy any remnants of love. Therapists must help borderline patients recognize that hate is a ubiquitous emotion that must be integrated and tempered with love so that aggression is harnessed in more constructive directions. As I have noted elsewhere, "We help patients learn to live within their own skin, squarely within the dialectic created by love and hate and by life and destructiveness" (Gabbard 1996, p. 231).

Establish and maintain the therapeutic alliance. Because the therapeutic alliance cannot be taken for granted with patients who have BPD, therapists must be attuned to the vicissitudes of the alliance from moment to moment and from session to session. Forging an alliance does not mean that one agrees with everything the patient says. However, it does mean that there was an ongoing effort to collaborate with the patient in understanding what the patient is perceiving and to reassess the treatment goals and be flexible in how they are modified so that therapist and the patient are pursuing common goals in the therapy. Borderline patients have significant difficulties with the task of cooperating with another person (King-Casas et al. 2008).

Moreover, because of the proneness of patients with borderline personality disorder to misinterpret neutral faces as potentially malevolent or uncaring, therapists must be aware of nonverbal communications they may send out. Also, the proverbial "blank screen face" is often a mistake made by beginning therapists that will play havoc with the alliance formation when one is treating BPD. It is much better to engage in spontaneous and warm dialogue with the patient while respecting the fact that there may be some suspiciousness of the therapist's motives. An implication of the research data on facial morphing is the awareness that patients with BPD have the capacity to identify emotional expressions earlier than most people because of their hyperattunement to the affective state of others. Hence, therapists need to be aware that this highly developed sensitivity may facilitate earlier identification of unconscious emotional states of the therapist. The patient may recognize that the therapist is becoming bored or irritated earlier than the therapist's awareness of the feeling. Therapists must avoid an automatic denial of the emotional state attributed to them by the patient. A more constructive approach to maintaining the alliance is to entertain the possibility that the patient is correctly perceiving something that is outside the consciousness of the therapist (Gabbard 2012).

Monitor countertransference feelings. Implicit in this entire discussion of psychotherapy has been the centrality of attending to the countertransference. Containing the projected parts of the patient and reflecting on the nature of these projections will help the therapist understand the patient's internal world (Gabbard and Wilkinson 1994). Moreover, ongoing attention to one's own feelings prevents countertransference acting-out. Each therapist has personal limits regarding how much hatred or anger is tolerable. If the therapist closely monitors countertransference feelings, this limit can be handled constructively rather than destructively. For example, a therapist might use countertransference feelings therapeutically by saying to the patient, "I'm getting the feeling that you are trying to make me angry at you instead of letting me help you. Let's see if we can understand what's happening here." Alternatively, the therapist may have to set limits on the patient's verbal barrages based on countertransference reactions, as follows: "I really don't feel I can work with you effectively if you continue to shout at me. I think it's important for you to work on controlling your anger so you can express it to me without screaming." Therapists must be real and genuine with borderline patients, or they will only increase the patient's envy of them as saintly figures that are basically nonhuman (Searles 1986).

The following clinical example of a psychotherapy session with Ms. CC, a 22-year-old borderline patient, illustrates some of the principles of technique just described:

(*Ms. CC arrives at her session after having missed the previous one. She begins the session by engaging the therapist in banter about a book on his bookshelf.*)

MS. CC: Hey, you got a new book.

THERAPIST: No, that book's always been there.

MS. CC: No, it hasn't. I would have noticed it before.

THERAPIST: Oh, I'm quite sure it has been there. But I'd really like to change the subject and find out more about why you didn't show up last time.

(*The therapist engages in some spontaneous preliminary banter but eventually returns to the serious matter of the patient's absence from the last session.*)

MS. CC: I just didn't feel like coming to therapy. I didn't want to have to deal with the feelings that I was having in here.

THERAPIST: Did you get my call on your machine?

(*The therapist, worrying about the patient's suicidality, had called the patient at home when she did not show up for the session.*)

MS. CC: Yes. I was there when you left your message on the machine.

THERAPIST: Why didn't you pick up the phone?

MS. CC: Oh, I didn't pick up any of my calls. I didn't want to talk to anyone.

THERAPIST: You remember that I asked you to return my call?

MS. CC: I know, but I was too embarrassed to call you back.

THERAPIST: What did you imagine about how I might react to that?

(*The therapist encourages mentalization by inviting the patient to explore her fantasies of his countertransference.*)

MS. CC: I didn't really think much about that.

(*The patient demonstrates lack of mentalization by not reflecting on internal states in self or others.*)

THERAPIST: Were you concerned that I might be worried about your hurting yourself?

MS. CC: Yes, I guess I did worry about that. I'm sorry. I won't do it again.

THERAPIST: I'd like to get beyond just being sorry about it and see if we can understand what's going on in your mind at those moments, because it really affects our ability to work together when you don't come to the therapy.

(*The therapist makes it clear that one of the conditions necessary to make the therapy viable is for the patient to attend the sessions regularly.*)

MS. CC: I was just into myself at the time. I was kind of in a funk.

THERAPIST: About what?

MS. CC: I don't know.

THERAPIST: Well, let's don't accept "I don't know." Let's try to see what reasons there might be.

(*The patient does not want to reflect on her internal state, but the therapist encourages further elaboration beyond the knee-jerk dismissal.*)

Ms. CC: Well, I just feel like everybody's going to forget about me. Nobody's going to care what I do or what my needs are.

Therapist: But you've been telling me that you can't stand the way your parents intrude into your life and hover over you all the time.

Ms. CC: I know, but that's because I'm always screwing up.

Therapist: Do you imagine that if you stop screwing up and become responsible, then no one will pay any attention to you?

(*The therapist poses a possible interpretation or explanation of the patient's behavior as a question for the patient to entertain and reflect upon rather than a forceful declaration of fact.*)

Ms. CC: I just think everyone will forget about me.

Therapist: I have an idea about that. I wonder if you forget about people when you're not around them, so you worry that others will do the same about you.

(*The therapist presents an interpretive understanding of her concern based on his awareness of her poor object constancy or evocative memory.*)

Ms. CC: I can't keep people in my mind. I can't picture your face when I'm not with you. I can't picture either of my parents' faces or my brother's face. It's just like they're not there. I've never been able to do that.

Therapist: Then I can imagine that it's hard for you to think about how people are reacting to you when you're away from them. Just like last Thursday when you missed our session. At that time it was probably difficult for you to imagine me sitting here wondering where you were and why you hadn't called.

(*The therapist empathically communicates his understanding of the patient's difficulties with mentalization and evocative memory.*)

Ms. CC: I just didn't think about it. Part of it was I just get tired of being in treatment. There's something else I haven't told you. I stopped my Prozac.

Therapist: When?

Ms. CC: About a week ago.

Therapist: Why didn't you discuss this with me so we could talk about the pros and cons of doing that?

(*The therapist's countertransference frustration emerges as he begins to identify with the policing parent who wants to coerce the patient into doing whatever he says.*)

Ms. CC: I just knew you'd say no.

Therapist: I'm still not clear though on why you stopped it.

Ms. CC: I just don't want to be a patient. I like therapy okay, but I don't want to take medication.

Therapist: I guess the thing that bothers me the most about this is that you didn't talk with me about what you were thinking of doing. It's similar to not showing up Thursday, not calling me, not returning my calls when I called you. It's like there's a part of you that sees me as an adversary and doesn't want to collaborate with me on major decisions, like stopping your Prozac or coming to therapy.

Ms. CC: It's like everybody is scrutinizing me and watching my every move. Everyone tries to catch me doing something wrong.

THERAPIST: Well, if you experience me in that way, I can see why you would stay away from therapy. I think it's important for us to keep in mind that you're here because you want to get over the suicidality and lead a more productive life.

(*The therapist explores the emerging negative transference and the adversarial role in which he has been cast as a way of promoting a therapeutic alliance and returning to the original goals of the therapy.*)

A common issue in the monitoring of countertransference is that many of the feelings engendered by the patient are unconscious. Hence, the therapist may become aware of them only because of subtle enactments, such as starting a session late or ending it early. Countertransference is something that a consultant or supervisor may detect before the therapist is aware of unconscious feelings developing toward the patient, and therapists should feel free to explore countertransference with a consultant or supervisor in the course of the therapy. Some therapists are embarrassed about the intensity of their feelings—positive or negative—and they are reluctant to share such feelings with the supervisor for fear of disapproval by the supervisor. However, a basic axiom that all therapists should remember is that the feeling or enactment that one most wishes to conceal from the supervisor is exactly what the therapist *should* be discussing with the supervisor.

Hospital and Partial Hospital Treatment

The principles of psychoanalytically informed hospital and partial hospital treatment are outlined in Chapter 6. In addition, the management of splitting, an essential ingredient in work with borderline patients, is also discussed in that chapter. Readers are therefore referred back to Chapter 6 for the basic principles of the milieu treatment of borderline patients. Several other points specific to patients with BPD are covered here.

In the hospital, borderline patients can disrupt units as their internal chaos is externalized into the milieu. Some become "special" patients who create intense countertransference problems related to splitting and projective identification (Burnham 1966; Gabbard 1986; Main 1957). Others are extraordinarily hateful and venomously attack all staff members who attempt to help them (Gabbard 1989b), creating a sense of futility in the staff. Still others may be passively oppositional and refuse to participate in any aspect of the treatment plan (Gabbard 1989a). Although these patients' illness may seem treatment refractory, some may ultimately benefit from treatment through careful attention to the individual dynamics of the patient and the staff countertransference.

A great deal of lore exists on the hospital treatment of borderline patients, much of it based on little or no solid data. Some clinicians think that hospitalization should not be used for borderline patients because it will promote regression and dependency. No hard data support this premise, but at least one controlled study has shown that hospital treatment can be quite beneficial for patients with severe personality disorders. In the United Kingdom, Dolan et al. (1997) examined a group of 137 consecutive patients with severe personality disorder on referral and at 1-year posttreatment at Henderson Hospital. Seventy of those referred were admitted and 67 were not. The researchers noted a significantly greater reduction of Borderline Syndrome Index scores in the admitted group compared with those who were not admitted. Also, the changes in scores were significantly positively correlated with the length of the hospital treatment.

Much of the treatment that was formerly carried out in hospital settings is now being conducted in day or partial hospital settings. The impressive outcomes in the Halliwick Day Unit (Bateman and Fonagy 1999, 2001) suggest that this modality may have great promise for future treatment of personality disorders. Piper et al. (1993) also had success in treating personality disorders in a randomized trial of day treatment. Wilberg et al. (1999) demonstrated positive outcomes with personality disorder patients treated in a day hospital. To determine if day treatment was successful outside of academic settings, Karterud et al. (2003) tested 1,010 personality disorder patients in eight different treatment programs in the Norwegian Network of Psychotherapeutic Day Hospitals from 1993 to 2000. Completers with personality disorders, including many who were borderline, improved significantly on all outcome variables from admittance to discharge, and improvement was maintained or increased at follow-up. Hence day hospital is now well established as a highly effective approach for borderline and other patients with severe personality disorders. The same principles of treatment used in extended hospital treatment in years past can be usefully applied to patients in day treatment.

Some patients do well in outpatient psychotherapy for the most part but periodically require brief hospitalization in the course of psychotherapy because of a transient period when they are intensely suicidal, self-destructive, or somewhat out of touch with reality. There may be varying degrees of turmoil in the psychotherapy process as well. Because the goal of short-term hospitalization is rapid restoration of the patient's defenses and adaptive functioning, the inpatient staff must convey a counterregressive expectation. Treaters in the milieu must communicate to such patients that they can control impulses despite their disclaimers. Although external controls, such as restraints and antipsychotic medication, may be necessary at times, the emphasis is on helping these patients take responsibility for self-control. The

weakened ego of the patient can be supplemented with a firm, consistent structure involving a regular schedule, clear consequences for impulsive acting out, and a predictable pattern of group and individual meetings with staff members and other patients.

The usual tendency of the newly admitted borderline patient is to expect, on demand, lengthy individual sessions with members of the nursing staff. When nurses are actually "roped into" attempting to gratify these demands, the patient typically deteriorates in direct proportion to the amount of time spent in these one-to-one "therapy" sessions. Borderline patients do much better when the nursing staff can build brief 5- to 10-minute meetings into the regular structure.

Staff members in the milieu and the unit structure itself function as auxiliary egos for borderline patients. Rather than attempting exploratory or interpretive work, the unit staff can help patients identify precipitants of their crises, delay impulse discharge by seeking alternatives, anticipate consequences of their actions, and clarify their internal object relations (as described in Chapter 6). Another function of brief hospitalization is that it affords a more accurate view of the patient's internal world. Finally, the milieu staff can often assist the psychotherapist in understanding the nature of a crisis or impasse that occurs in the patient's psychotherapy. In addition to addressing any splitting processes (as described in Chapter 6), the milieu staff can help the therapist by validating the therapist's competence and worth as a clinician (Adler 1984). From the self psychological perspective of Adler, the unit nurses and other personnel can perform selfobject functions for both the patient and the therapist (Adler 1987).

There must also be a unit norm that discourages keeping secrets. Anything the patient says to one staff member must be shared with other staff members in meetings. The staff of the unit must be able to repeatedly say "no" to the patient in a matter-of-fact, caring way that conveys no malice. Otherwise, the patient may not be able to integrate the fact that "good" caring figures are the same persons who implement restrictive measures (i.e., "bad" interventions). This integration of internal self and object representations is another primary goal of extended inpatient treatment.

Limits applied to a patient must always be based on an empathic understanding of the patient's need for limits rather than on any sadistic attempt at control, which is how the patient usually views such restrictions.

Suicidal and self-mutilative behavior is often a significant problem because borderline patients attempt to control the entire treatment staff just as they have controlled their family and loved ones with such behavior. The staff members must stress that each patient is ultimately responsible for controlling such behavior and that realistically no one can prevent a patient from committing suicide. Borderline patients often make superficial cuts on

themselves with paper clips, beverage cans, light bulbs, and other objects that are generally available even in hospitals. Although the actual damage from such superficial scratching may be minimal, the unit staff should carefully investigate the origins of the mutilation. Is it connected with depersonalization episodes or dissociation? Is there a history of childhood sexual abuse? Does the patient's condition warrant a trial of fluoxetine? Is the behavior primarily manipulative in an effort to gain attention from the staff?

The chronically suicidal borderline patient may engender intense countertransference feelings in staff members, who perceive the attempts and gestures as manipulative and therefore begin to react to the patient's suicidal threats with a lack of concern. The inpatient staff must keep in mind that suicide attempters are 140 times more likely to commit suicide than nonattempters (Tuckman and Youngman 1963) and that roughly 10%–20% of all suicide attempters eventually kill themselves (Dorpat and Ripley 1967).

Family Therapy

Therapeutic modification of the borderline patient's internal object world generally requires an intensive individual psychotherapy process. Work with the family, however, is often an essential adjunct to the overall treatment plan. There was a time when parents were often blamed for the child who developed borderline personality disorder. Although destructive parenting may be part of the picture, in many other cases the parents are reacting to a child born with a difficult temperament that creates conflicts throughout the family. The first step is to involve the parents as collaborators. To that end it is helpful to do a good deal of basic psychoeducation with spouses, partners, or parents as part of the treatment of the designated patient. This collaborative approach may help the parents or significant others feel motivated to participate in some form of family therapy.

Family involvement in the treatment may take many forms short of family therapy as well. The psychoeducation may lead to counseling or support groups, such as those sponsored by consumer organizations that have formed in response to the widespread prevalence of borderline personality disorder. Sometimes these meetings involve multiple family groups. In addition, conjoint sessions in which the patient and the parents engage in problem solving may be valuable as well. Formal family therapy is best reserved for those patients and parents who can discuss their conflicts without exploding in anger or disrupting the meeting by leaving. Attributing responsibility to parents may be useful if the parents can accept with regrets whatever is true from the patient's allegations (Gunderson 2014).

As described in Chapter 5, splitting and projective identification are extremely common mechanisms that serve to maintain a pathological homeo-

stasis in the family system. For example, a parent may ward off bad internal self or object representations and project them onto an adolescent or young adult offspring, who subsequently identifies with these projections and becomes the symptomatic member of the family.

In diagnosing family patterns, therapists should avoid imposing their own theoretical constructs on the family. For example, although certain psychodynamic models (Masterson and Rinsley 1975) might presuppose overinvolvement on the part of the mother, empirical research (Gunderson and Englund 1981; Gunderson et al. 1980) has suggested that overinvolved parents are less common than neglectful ones. Neglectful parents of borderline patients tend to be needy themselves and therefore often fail to provide their children with guidance in the form of rules or "structure."

In families in which overinvolvement is a pervasive pattern, family intervention must respect the needs of each family member for the other members. The parents may have borderline psychopathology themselves and may be terribly threatened by the prospect of "losing" their borderline offspring through treatment. Clinicians must take seriously the possibility that a significant improvement in the patient may result in a severe decompensation in a parent, who will be thrown into a panic because of the perceived separation (Brown 1987). In these instances, a family therapist should help the family deal with the dilemmas created by change in the patient as well as in the family system as a whole. The therapist must conscientiously avoid any attempt to "pry apart" the borderline patient and the family. Such efforts will be viewed by both the family and the patient as a highly threatening attack that will simply cause them to "circle the wagons" and increase their enmeshment. Family therapists produce better results when they assume a nonjudgmental, neutral position regarding change, empathizing with the family's need to remain together because of the stability inherent in the overinvolvement (Jones 1987). Any change in the system must come from *within* rather than being imposed by mental health professionals, who traditionally place a high value on separation and autonomy.

Another crucial principle in working with the families of BPD patients is to avoid siding with the patient's vilification of the parents as though every monstrous report is completely accurate. In a study comparing BPD patients' perceptions of their families with the perceptions of their parents and those of normative families, Gunderson and Lyoo (1997) found that borderline patients perceived their family relationships in a significantly more negative light than did either the parents or the normative families. Parents tend to agree with each other but not with the borderline offspring. This schism in the family must be taken seriously. Clinicians should keep in mind that the borderline patient's account may be colored by his or her own psychological propensities while also recognizing that the parents' view must be accepted

with caution as well. Many parents will have defensive responses during an assessment and feel as though they are being blamed for the child's difficulties. In most cases, the truth lies somewhere between the two viewpoints, and each side's perceptions have some validity.

Group Psychotherapy

Group psychotherapy may also be a beneficial adjunct to individual psychotherapy of borderline patients. As Ganzarain (1980) and Horwitz (1977) noted, all groups are prone to employ the borderline defenses of splitting and projective identification. Group psychotherapy affords the borderline individual an opportunity to understand these defenses as they occur in a group context. Most contributors to the literature on group psychotherapy of the borderline patient, however, suggest that the borderline patient is most effectively treated in groups of patients who have neuroses or higher-level personality disorders (Day and Semrad 1971; Horwitz 1977; Hulse 1958; Slavson 1964).

Likewise, the consensus of the literature is that borderline patients in group psychotherapy need concomitant individual psychotherapy (Day and Semrad 1971; Horwitz 1977; Hulse 1958; Slavson 1964; Spotnitz 1957). The dilution of transference in group psychotherapy significantly benefits both the borderline patient and the therapist. The intense rage that is ordinarily mobilized in borderline patients when they are frustrated in treatment may thus be diluted and directed toward other figures besides the individual therapist. Similarly, the strong countertransference reactions to borderline patients may be diluted by the presence of other people.

Horwitz (1977) pointed out that the individual psychotherapist may serve a crucial supportive function when the borderline patient's anxiety escalates in response to confrontation in the group setting. The individual therapist ideally should be someone other than the group therapist, because "it is antitherapeutic for the group therapist to see some patients individually while not seeing others privately as well" (p. 415). Horwitz also identified abrasive characterological traits as an indication for group psychotherapy in addition to individual psychotherapy. He observed that borderline patients seem more willing to accept confrontation and interpretation about such traits from their peers in group psychotherapy than from a therapist. They may also find it easier to accept their therapist's interpretations as part of a group-centered theme than when the interpretations single them out as individuals.

Empirical data are emerging that corroborate the widespread clinical impression that group treatment may be quite useful for borderline patients. Although not a psychodynamic modality, DBT (Linehan et al. 1991) uses

groups as its cornerstone and has been shown to reduce self-mutilating and suicidal behaviors. In a randomized controlled trial of interpersonal group psychotherapy versus individual dynamic therapy, Munroe-Blum and Marziali (1995) found that 25 weekly sessions of 90-minute group therapy followed by 5 biweekly sessions leading to termination resulted in significant improvements. Analysis at 12- and 24-month follow-up showed significant improvements on all major outcomes. Moreover, the group patients did as well as those in individual therapy. Finally, thrice-weekly dynamic group therapy was central to the efficacious approach used by Bateman and Fonagy (1999, 2001) at the Halliwick Day Unit.

Despite the advantages of working in a group context, therapists will find certain inherent difficulties in the group psychotherapy of borderline patients. Such patients may easily become scapegoated because of their more primitive psychopathology and their greater tendency to express affect in a direct manner. The therapist may be required to support the borderline patient when scapegoating emerges as a group theme. Moreover, borderline patients may also experience an increase in their feelings of deprivation because of competition with the group for the nurturance of the therapist. Finally, borderline patients tend to maintain a certain distance in group psychotherapy because of their primary attachment to the individual therapist.

References

Adler G: The myth of the alliance with borderline patients. Am J Psychiatry 47:642–645, 1979

Adler G: Issues in the treatment of the borderline patient, in Kohut's Legacy: Contributions to Self Psychology. Edited by Stepansky PE, Goldberg A. Hillsdale, NJ, Analytic Press, 1984, pp 117–134

Adler G: Borderline Psychopathology and Its Treatment. New York, Jason Aronson, 1985

Adler G: Discussion: milieu treatment in the psychotherapy of the borderline patient: abandonment and containment. Yearbook of Psychoanalysis and Psychotherapy 2:145–157, 1987

Akiskal HS, Chen SE, Davis GC, et al: Borderline: an adjective in search of a noun. J Clin Psychiatry 46:41–48, 1985

Alexander PC, Anderson CL, Brand B, et al: Adult attachment and long-term effects in survivors of incest. Child Abuse Negl 22:45–61, 1998

Allen JG: Traumatic Relationships and Serious Mental Disorders. New York, Wiley, 2001

American Psychiatric Association: Practice Guideline for the Treatment of Patients With Borderline Personality. Washington, DC, American Psychiatric Association, 2001

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Andrulonis PA: Disruptive behavior disorders in boys and the borderline personality disorder in men. Ann Clin Psychiatry 3:23–26, 1991

Baker L, Silk KR, Westen D, et al: Malevolence, splitting, and parental ratings by borderlines. J Nerv Ment Dis 180:258–264, 1992

Baron-Cohen S, Ring HA, Wheelwright S, et al: Social intelligence in the normal and autistic brain: an fMRI study. Eur J Neurosci 11:1891–1898, 1999

Baron-Cohen S, Wheelwright S, Hill J, et al: The "Reading the Mind in the Eyes" test revised version: a study with normal adults, and adults with Asperger syndrome or high-functioning autism. J Child Psychol Psychiatry 42:241–251, 2001

Bateman A, Fonagy P: Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. Am J Psychiatry 156: 1563–1569, 1999

Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry 158:36–42, 2001

Bateman A, Fonagy P: Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. Am J Psychiatry 160:169–171, 2003

Bateman AW, Fonagy P: Mentalization-based treatment of BPD. J Pers Disord 18: 36–51, 2004a

Bateman A, Fonagy P: Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment. Oxford, UK, Oxford University Press, 2004b

Bateman A, Fonagy P: Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry 166:1355–1364, 2009

Battle CL, Shea MT, Johnson DM, et al: Childhood maltreatment associated with adult personality disorders: findings from the Collaborative Longitudinal Personality Disorder Study. J Pers Disord 18:193–211, 2004

Bion WR: Clinical Seminars and Other Works. London, Karnac, 1987

Blum N, St. John D, Pfohl B, et al: Systems Training for Emotional Predictability and Problem Solving (STEPPS) for outpatients with borderline personality disorder: a randomized controlled trial and one year follow-up. Am J Psychiatry 165:468–478, 2008

Brown SL: Family therapy and the borderline patient, in The Borderline Patient: Emerging Concepts in Diagnosis, Psychodynamics, and Treatment, Vol 2. Edited by Grotstein JS, Solomon MF, Lang JA. Hillsdale, NJ, Analytic Press, 1987, pp 206–209

Burnham DL: The special-problem patient: victim or agent of splitting? Psychiatry 29:105–122, 1966

Calarge C, Andreasen NC, O'Leary DS: Visualizing how one brain understands another: a PET study of theory of mind. Am J Psychiatry 160:1954–1964, 2003

Clarkin JF, Levy KN, Lenzenweger MF, et al: The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomized control trial for borderline personality disorder: rationale, methods, and patient characteristics. J Pers Disord 18:52–72, 2004

Clarkin JF, Lenzenweger MF, Yeomans F, et al: An object relations model of borderline pathology. J Pers Disord 21:474–499, 2007a

Clarkin JF, Levy KN, Lenzenweger MF, et al: Evaluating three treatments for patients with borderline personality disorder: a preliminary multi-wave study of behavioral change. Am J Psychiatry 164:922–928, 2007b

Colson DB, Lewis L, Horwitz L: Negative outcome in psychotherapy and psychoanalysis, in Negative Outcome in Psychotherapy and What to Do About It. Edited by Mays DT, Frank CM. New York, Springer, 1985, pp 59–75

Day M, Semrad E: Group therapy with neurotics and psychotics, in Comprehensive Group Psychotherapy. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1971, pp 566–580

Dolan B, Warren F, Norton K: Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. Br J Psychiatry 171: 274–279, 1997

Donegan NH, Sanislow CA, Blumberg HP, et al: Amygdala hyperreactivity in borderline personality disorder: implications for emotional dysregulation. Biol Psychiatry 54:1284–1293, 2003

Dorpat TL, Ripley HS: The relationship between attempted suicide and committed suicide. Compr Psychiatry 8:74–79, 1967

Driessen M, Herrmann J, Stahl K: Magnetic resonance imaging volumes of the hippocampus and the amygdala in women with borderline personality disorder and early traumatization. Arch Gen Psychiatry 57:1115–1122, 2000

Fertuck EA, Song JA, Morris WB, et al: Enhanced "reading the mind in the eyes" in borderline personality disorder compared to healthy controls. Psychol Med 39:1979–1988, 2009

Fonagy P: An attachment theory approach to treatment of the difficult patient. Bull Menninger Clin 62:147–169, 1998

Fonagy P: Attachment Theory and Psychoanalysis. New York, Other Press, 2001

Fonagy P, Target M: Playing with reality, III: the persistence of dual psychic reality in borderline patients. Int J Psychoanal 81:853–874, 2000

Fonagy P, Leigh T, Steele M, et al: The relationship of attachment status, psychiatric classification, and response to psychotherapy. J Consult Clin Psychol 64:22–31, 1996

Fonagy P, Steele M, Steele H, et al: Reflective Functioning Manual, Version 4.1, for Application to Adult Attachment Interviews. London, University of London, 1997

Frank H, Hoffman N: Borderline empathy: an empirical investigation. Compr Psychiatry 27:387–395, 1986

Frank H, Paris J: Recollections of family experience in borderline patients. Arch Gen Psychiatry 38:1031–1034, 1981

Frith CD, Frith U: Interacting minds: a biological basis. Science 286:1692–1695, 1999

Gabbard GO: The treatment of the "special" patient in a psychoanalytic hospital. International Review of Psychoanalysis 13:333–347, 1986

Gabbard GO: On "doing nothing" in the psychoanalytic treatment of the refractory borderline patient. Int J Psychoanal 70:527–534, 1989a

Gabbard GO: Patients who hate. Psychiatry 52:96–106, 1989b
Gabbard GO (ed): Sexual Exploitation in Professional Relationships. Washington, DC, American Psychiatric Press, 1989c
Gabbard GO: An overview of countertransference with borderline patients. J Psychother Pract Res 2:7–18, 1993
Gabbard GO: Love and Hate in the Analytic Setting. Northvale, NJ, Jason Aronson, 1996
Gabbard GO: Borderline personality disorder and rational managed care policy. Psychoanalytic Inquiry 17(suppl):17–28, 1997
Gabbard GO: Treatment-resistant borderline personality disorder. Psychiatr Ann 28: 651–656, 1998
Gabbard GO: Miscarriages of psychoanalytic treatment with suicidal patients. Int J Psychoanal 84:249–261, 2003
Gabbard GO: The therapeutic action in psychoanalytic psychotherapy of borderline personality disorder, in The Psychoanalytic Therapy of Severe Disturbance. Edited by Williams P. London, Karnac, 2010, pp 1–19
Gabbard GO: Neurobiologically informed psychotherapy of borderline personality disorder, in Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence. Edited by Levy RA, Ablon JS, Kachele H. New York, Humana Press, 2012, pp 257–268
Gabbard GO, Horowitz MJ: Insight, transference interpretation and therapeutic change in the dynamic psychotherapy of borderline personality disorder. Am J Psychiatry 166:517–521, 2009
Gabbard GO, Wilkinson SM: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press, 1994
Gabbard GO, Horwitz L, Frieswyk S, et al: The effect of therapist interventions on the therapeutic alliance with borderline patients. J Am Psychoanal Assoc 36: 697–727, 1988
Gabbard GO, Horwitz L, Allen JG, et al: Transference interpretation in the psychotherapy of borderline patients: a high-risk, high-gain phenomenon. Harv Rev Psychiatry 2:59–69, 1994
Gallagher HL, Happe F, Brunswick N, et al: Reading the mind in cartoons and stories: an fMRI study of "theory of mind" in verbal and nonverbal tasks. Neuropsychologia 38:11–21, 2000
Ganzarain RC: Psychotic-like anxieties and primitive defenses in group analytic psychotherapy. Issues in Ego Psychology 3:42–48, 1980
Giesen-Bloo J, van Dyck R, Spinhoven P, et al: Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs. transference-focused therapy. Arch Gen Psychiatry 63:649–658, 2006
Goel V, Grafman J, Sadato N, et al: Modeling other minds. Neuroreport 6:1741–1746, 1995
Goldberg RL, Mann LS, Wise TN, et al: Parental qualities as perceived by borderline personality disorders. Hillside J Clin Psychiatry 7:134–140, 1985
Gorney JE: The negative therapeutic interaction. Contemp Psychoanal 15:288–337, 1979

Gregory RJ, Delucia-Deranja E, Mogle JA: Dynamic deconstructive psychotherapy versus optimized community care for borderline personality disorder co-occurring with alcohol use disorders: 30 months follow-up. J Nerv Ment Dis 198:292–298, 2010

Grinker RR Jr, Werble B, Drye RC: The Borderline Syndrome: A Behavioral Study of Ego-Functions. New York, Basic Books, 1968

Gunderson JG: Studies of borderline patients in psychotherapy, in Handbook of Borderline Disorders. Edited by Silver D, Rosenbluth M. Madison, CT, International Universities Press, 1992, pp 291–305

Gunderson JG: The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. Am J Psychiatry 153:752–758, 1996

Gunderson JG: Borderline Personality Disorder: A Clinical Guide. Washington, DC, American Psychiatric Publishing, 2001

Gunderson J: Handbook of Good Psychiatric Management for Borderline Patients. Washington, DC, American Psychiatric Publishing, 2014

Gunderson JG, Chu JA: Treatment implications of past trauma in borderline personality disorder. Harv Rev Psychiatry 1:75–81, 1993

Gunderson JG, Englund DW: Characterizing the families of borderlines: a review of the literature. Psychiatr Clin North Am 4:159–168, 1981

Gunderson JG, Links P: Borderline Personality Disorder: A Clinical Guide. 2nd Edition. Washington, DC, American Psychiatric Publishing, 2008

Gunderson JG, Lyoo K: Family problems and relationships for adults with borderline personality disorder. Harv Rev Psychiatry 4:272–278, 1997

Gunderson JG, Sabo AN: The phenomenological and conceptual interface between borderline personality disorder and PTSD. Am J Psychiatry 150:19–27, 1993

Gunderson JG, Zanarini MC: Current overview of the borderline diagnosis. J Clin Psychiatry 48(suppl 8):5–14, 1987

Gunderson JG, Kerr J, Englund DW: The families of borderlines: a comparative study. Arch Gen Psychiatry 37:27–33, 1980

Gunderson JG, Stout RL, McGlashan TH, et al: Ten year course of borderline personality disorder: psychopathology and function from the collaborative longitudinal personality disorders studies. Arch Gen Psychiatry 68:827–837, 2011

Gutheil T: Borderline personality disorder, boundary violations, and patient–therapist sex: medicolegal pitfalls. Am J Psychiatry 146:597–602, 1989

Herman JL, Perry JC, van der Kolk BA: Childhood trauma in borderline personality disorder. Am J Psychiatry 146:490–495, 1989

Herpertz SC, Dietrich TM, Wenning B, et al: Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. Biol Psychiatry 50:292–298, 2001

Hoch P, Polatin P: Pseudoneurotic forms of schizophrenia. Psychiatr Q 23:248–276, 1949

Horwitz L: Clinical Prediction in Psychotherapy. New York, Jason Aronson, 1974

Horwitz L: Group psychotherapy of the borderline patient, in Borderline Personality Disorders: The Concept, the Syndrome, the Patient. Edited by Hartocollis PL. New York, International Universities Press, 1977, pp 399–422

Horwitz L, Gabbard GO, Allen JG, et al: Borderline Personality Disorder: Tailoring the Psychotherapy to the Patient. Washington, DC, American Psychiatric Press, 1996

Hulse WC: Psychotherapy with ambulatory schizophrenic patients in mixed analytic groups. Arch Neurol Psychiatry 79:681–687, 1958

Johnson JG, Cohen P, Brown J, et al: Childhood maltreatment increases risk for personality disorders during early adulthood. Arch Gen Psychiatry 56:600–606, 1999

Jones SA: Family therapy with borderline and narcissistic patients. Bull Menninger Clin 51:285–295, 1987

Karterud S, Pedersen G, Bjordal E, et al: Day treatment of patients with personality disorders: experiences from a Norwegian treatment research network. J Pers Disord 17:243–262, 2003

Kernberg OF: Borderline personality organization. J Am Psychoanal Assoc 15:641–685, 1967

Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Kernberg OF: Technical considerations in the treatment of borderline personality organization. J Am Psychoanal Assoc 24:795–829, 1976

Kernberg OF, Burstein ED, Coyne L, et al: Psychotherapy and psychoanalysis: final report of The Menninger Foundation's Psychotherapy Research Project. Bull Menninger Clin 36:3–275, 1972

Kernberg OF, Selzer MA, Koenigsberg HW, et al: Psychodynamic Psychotherapy of Borderline Patients. New York, Basic Books, 1989

King-Casas B, Sharp C, Lomax L, et al: The rupture and repair of cooperation in borderline personality disorder. Science 321:806–810, 2008

Knight RP: Borderline states. Bull Menninger Clin 17:1–12, 1953

Linehan MM, Armstrong HE, Suarez A, et al: Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry 48:1060–1064, 1991

Linehan MM, Comtois KA, Murray AM, et al: Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry 63:757–766, 2006

Links PS, Steiner M, Offord DR, et al: Characteristics of borderline personality disorder: a Canadian study. Can J Psychiatry 33:336–340, 1988

Lynch TR, Rosenthal MZ, Kosson DS, et al: Heightened sensitivity to facial expressions of emotion in borderline personality disorder. Emotion 6:647–655, 2006

Lyoo IK, Han MH, Cho DY: A brain MRI study in subjects with borderline personality disorder. J Affect Disord 50:235–243, 1998

Mahler MS, Pine F, Bergman A: The Psychological Birth of the Human Infant: Symbiosis and Individuation. New York, Basic Books, 1975

Main TF: The ailment. Br J Med Psychol 30:129–145, 1957

Maltsberger JT: Countertransference in the treatment of the suicidal borderline patient, in Countertransference Issues in Psychiatric Treatment (Review of Psychiatry Series, Vol. 18; Oldham JM and Riba MB, series eds). Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1999, pp 27–43

Masterson JF: Psychotherapy of the Borderline Adult: A Developmental Approach. New York, Brunner/Mazel, 1976

Masterson JF, Rinsley DB: The borderline syndrome: the role of the mother in the genesis and psychic structure of the borderline personality. Int J Psychoanal 56: 163–177, 1975

McMain SF, Links PS, Gnam WH, et al: A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. Am J Psychiatry 166:1365–1374, 2009

McMain SF, Guimond T, Streiner DL, et al: Dialectical behavior therapy compared with general psychiatric management for borderline personality disorder: clinical outcomes and functioning over a two-year follow-up. Am J Psychiatry 169:650–661, 2012

Meissner WW: Treatment of Patients in the Borderline Spectrum. Northvale, NJ, Jason Aronson, 1988

Modell AH: "The holding environment" and the therapeutic action of psychoanalysis. J Am Psychoanal Assoc 24:285–307, 1976

Munroe-Blum H, Marziali E: A controlled trial of short-term group treatment for borderline personality disorder. J Pers Disord 9:190–198, 1995

New AS, Stanley B: An opioid deficit in borderline personality disorder: self-cutting, substance abuse, and social dysfunction. Am J Psychiatry 167:882–885, 2010

Ochsner KN, Bunge SA, Gross JJ, et al: Rethinking feelings: fMRI study of the cognitive regulation of emotions. J Cogn Neurosci 14:1215–1229, 2002

Ogata SN, Silk KR, Goodrich S, et al: Childhood sexual and physical abuse in adult patients with borderline personality disorder. Am J Psychiatry 147:1008–1013, 1990

Oldham JM, AE, Kellman HD, et al: Diagnosis of DSM-III-R personality disorders by two structured interviews: patterns of comorbidity. Am J Psychiatry 149: 213–220, 1992

O'Leary KM: Neuropsychological testing results. Psychiatr Clin North Am 23:41–60, 2000

O'Leary KM, Cowdry RW: Neuropsychological testing results in borderline personality disorder, in Biological and Neurobehavioral Studies of Borderline Personality Disorder. Edited by Silk KR. Washington, DC, American Psychiatric Press, 1994, pp 127–157

Paris J: Does childhood trauma cause personality disorders in adults? Can J Psychiatry 43:148–153, 1998

Paris J: The outcome of borderline personality disorder: good for most but not all patients. Am J Psychiatry 169:445–446, 2012

Paris J, Frank H: Perceptions of parental bonding in borderline patients. Am J Psychiatry 146:1498–1499, 1989

Paris J, Zweig-Frank H: A critical review of the role of childhood sexual abuse in the etiology of borderline personality disorder. Can J Psychiatry 37:125–128, 1992

Patrick M, Hobson RP, Castle D, et al: Personality disorder and the mental representation of early experience. Developmental Psychopathology 6:375–388, 1994

Piper WE, Rosie JS, Azim HF, et al: A randomized trial of psychiatric day treatment for patients with affective and personality disorders. Hosp Community Psychiatry 44:757–763, 1993

Prossin AR, Love TM, Koeppe RA, et al: Dysregulation of regional endogenous opioid function in borderline and schizotypal personality disorder. Am J Psychiatry 167:925–933, 2010

Reichborn-Kjennerud T, Ystrom E, Neale MC, et al: Structure of genetic and environmental risk factors for symptoms of DSM-IV borderline personality disorder. JAMA Psychiatry 70:1206–1214, 2013

Rinne T, de Kloet ER, Wouters L, et al: Hyperresponsiveness of hypothalamic-pituitary-adrenal axis to combined dexamethasone/corticotropin-releasing hormone challenge in female borderline personality disorder subjects with a history of sustained childhood abuse. Biol Psychiatry 52:1102–1112, 2002

Rosen IR: Relational masochism: the search for a bad enough object. Paper presented at scientific meeting of the Topeka Psychoanalytic Society, Topeka, KS, January 1993

Rüsch N, Lieb K, Göttler I, et al: Shame and implicit self-concept in women with borderline personality disorder. Am J Psychiatry 164:500–508, 2007

Sandler J: Character traits and object relationships. Psychoanal Q 50:694–708, 1981

Schiffer F, Teicher MH, Papanicolaou AC: Evoked potential evidence for right brain activity during the recall of traumatic memories. J Neuropsychiatry Clin Neurosci 7:169–175, 1995

Schmahl CG, Vermetten E, Elzinga BM, et al: Magnetic resonance imaging of hippocampal and amygdalar volume in women with childhood abuse and borderline personality disorder. Psychiatry Res 122:193–198, 2003a

Schmahl CG, Elzinga BM, Vermetten E, et al: Neural correlates of memories of abandonment in women with and without borderline personality disorder. Biol Psychiatry 54:142–151, 2003b

Schmideberg M: The borderline patient, in American Handbook of Psychiatry, Vol 1. Edited by Arieti S. New York, Basic Books, 1959, pp 398–416

Searles HF: My Work With Borderline Patients. Northvale, NJ, Jason Aronson, 1986

Silbersweig D, Clarkin JR, Goldstein M, et al: Failure of frontolimbic inhibitory function in the context of negative emotion in borderline personality disorder. Am J Psychiatry 164:1832–1841, 2007

Slavson SR: A Textbook in Analytic Group Psychotherapy. New York, International Universities Press, 1964

Soloff PH, Millward JW: Developmental histories of borderline patients. Compr Psychiatry 24:574–588, 1983

Spotnitz H: The borderline schizophrenic in group psychotherapy: the importance of individualization. Int J Group Psychother 7:155–174, 1957

Stalker CA, Davies F: Attachment organization, and adaptation in sexually abused women. Can J Psychiatry 40:234–240, 1995

Streeter CC, vanReekum R, Shorr RI, et al: Prior head injury in male veterans with borderline personality disorder. J Nerv Ment Dis 183:577–581, 1995

Swartz M, Blazer D, George L, et al: Estimating the prevalence of borderline personality disorder in the community. J Pers Disord 4:257–272, 1990

Swirsky-Sacchetti T, Gorton G, Samuel S, et al: Neuropsychological function in borderline personality disorder. J Clin Psychol 49:385–396, 1993

Torgersen S, Kringlen E, Cramer V: The prevalence of personality disorders in a community sample. Arch Gen Psychiatry 58:590–596, 2001

Torgersen S, Lygren S, Oien PA, et al: A twin study of personality disorders. Compr Psychiatry 41:416–425, 2000

Tuckman J, Youngman WF: Suicide risk among persons attempting suicide. Public Health Rep 78:585–587, 1963

van Elst TL, Hesslinger B, Thiel T, et al: Frontolimbic brain abnormalities in patients with borderline personality disorder: a volumetric magnetic resonance imaging study. Biol Psychiatry 54:163–171, 2003

vanReekum R, Conway CA, Gansler D, et al: Neurobehavioral study of borderline personality disorder. J Psychiatry Neurosci 18:121–129, 1993

Wagner AW, Linehan MM: Facial expression recognition ability among women with borderline personality disorder: implications for emotion regulation? J Pers Disord 13:329–344, 1999

Waldinger RJ: Intensive psychodynamic therapy with borderline patients: an overview. Am J Psychiatry 144:267–274, 1987

Wallerstein RS: Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy. New York, Guilford, 1986

Walsh F: The family of the borderline patient, in The Borderline Patient. Edited by Grinker RR, Werble B. New York, Jason Aronson, 1977, pp 158–177

Westen D, Ludolph P, Misle B, et al: Physical and sexual abuse in adolescent girls with borderline personality disorder. Am J Orthopsychiatry 60:55–66, 1990

Widiger TA, Weissman MM: Epidemiology of borderline personality disorder. Hosp Community Psychiatry 42:1015–1021, 1991

Wilberg T, Urnes O, Friis S, et al: One-year follow-up of day treatment for poorly functioning patients with personality disorders. Psychiatr Serv 50:1326–1330, 1999

Winnicott DW: Transitional objects and transitional phenomena—a study of the first not-me possession period. Int J Psychoanal 34:59–97, 1953

Zanarini MC, Frankenburg FR: Pathways to the development of borderline personality disorder. J Pers Disord 11:93–104, 1997

Zanarini MC, Frankenburg FR: The essential nature of borderline psychopathology. J Pers Disord 21:518–535, 2007

Zanarini MC, Gunderson JG, Frankenburg FR: Axis I phenomenology of borderline personality disorder. Compr Psychiatry 30:149–156, 1989a

Zanarini MC, Gunderson JG, Marino MF, et al: Childhood experiences of borderline patients. Compr Psychiatry 30:18–25, 1989b

Zanarini MC, Gunderson JG, Frankenburg FR, et al: Discriminating borderline personality disorder from other Axis II disorders. Am J Psychiatry 147:161–167, 1990

Zanarini MC, Williams AA, Lewis RE, et al: Reported pathological childhood experiences associated with the development of borderline personality disorder. Am J Psychiatry 154:1101–1106, 1997

Zanarini MC, Frankenburg FR, Reich DB, et al: Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and Axis II comparison subjects: a 16-year prospective follow-up study. Am J Psychiatry 169:476–483, 2012

Zetzel ER: A developmental approach to the borderline patient. Am J Psychiatry 127:867–871, 1971

Zlotnick C, Rothschild L, Zimmerman M: The role of gender in the clinical presentation of patients with borderline personality disorder. J Pers Disord 16:277–282, 2002

Zweig-Frank H, Paris J: Parents' emotional neglect and overprotection according to the recollections of patients with borderline personality disorder. Am J Psychiatry 148:648–651, 1991

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CHAPTER 16

CLUSTER B PERSONALITY DISORDERS

Narcissistic

> O, you are sick of self-love, Malvolio, and taste with a distemper'd appetite. To be generous, guiltless, and of free disposition, is to take those things for birdbolts[1] that you deem cannon bullets.
>
> *Olivia in Act I, Scene v of Shakespeare's Twelfth Night*

In Shakespeare's comedy, it is clear to both Olivia and the audience that Malvolio's love of himself and his tendency to experience mild slights as devastating attacks are indications that he is "sick." In contemporary psychiatric practice, however, the distinction between healthy and pathological degrees of narcissism is fraught with difficulty. A certain measure of healthy self-interest and self-love is not only normal but also essential for psycho-

[1]Blunt-headed arrows for shooting birds.

logical health. Yet the point on the continuum of self-regard where healthy narcissism turns into pathological narcissism is not easy to identify.

Another confounding factor is that certain behaviors may be pathologically narcissistic in one individual while simply a manifestation of healthy self-regard in another. Narcissism is judged differently depending on the phase of the life cycle through which one is passing. Even though we are aware of these developmental distinctions, the term *narcissistic* is rarely used as a compliment to refer to someone with healthy self-esteem. On the contrary, the term is almost always used pejoratively, especially when referring to colleagues and acquaintances whom we find unpleasant. Also, the term is often invoked to refer to someone whose success and confidence we envy. Because we all struggle with narcissistic issues, we must always be wary of the potential for hypocrisy in labeling others as narcissistic.

To complicate things further, we live in a narcissistic culture. In 1979, Christopher Lasch argued that a culture of narcissism had developed in response to our slavish devotion to electronic media that thrived on superficial images while ignoring substance and depth (Lasch 1979). Today's generation of "Millenials," who live their lives on Facebook and other social media, with an electronic device "glued" to their hands, has created a new version of narcissistic culture. As Twenge and Campbell (2009) have noted, self-esteem and narcissism have invaded the social discourse of our society. Narcissism was rarely mentioned in the popular press during the early 1970s, but between 2002 and 2007, there were 5,000 mentions. Since 1975 somewhere between 5 and 10 books on narcissism have been published each year, but there were fewer than 3 books in circulation published before 1970. A study of narcissistic personality disorder sponsored by the National Institutes of Health (Stinson et al. 2008) found that there were nearly three times more persons meeting criteria for narcissistic personality disorder (NPD) in the age group from 20 to 29 than in the age group over 65. On the cover of *Time* magazine, the Millenials were featured as the "Me, Me, Me Generation" (J. Stein 2013). Many of the young adults in this generation have grown up with a sense of entitlement that they deserve to be famous or well paid without putting forth much effort to achieve their dreams. They have grown up with an audience of peers on social media who have offered instant gratification and enhancement of self-esteem on an ongoing basis throughout the day and even into the wee hours of the night.

Given this cultural ambience, it is often problematic to determine which traits indicate a narcissistic personality disorder and which are simply adaptive cultural traits. Moreover, the difference between a healthy self-esteem and an artificially inflated self-esteem is often ambiguous. Let us visualize, for example, a mental health professional presenting a scientific paper to an audience of peers. The presenter notices that about half the audience is fall-

ing asleep during his presentation, whereas others are getting up and leaving. During the discussion period at the end of the presentation, the presenter is severely criticized for "muddy thinking," "insufficient familiarity with the literature," and "presenting nothing new." He responds to these criticisms by saying to himself, "No matter what they think, I know I'm competent anyway." How do we evaluate this response? Based on the information in this example, we could reach one of two conclusions: 1) this person has a healthy self-regard that does not collapse merely because of one untoward experience, or 2) the presenter's response is reflective of pathological narcissism in that it is a grandiose defensive reaction to compensate for a devastating injury to his self-esteem.

With such a bewildering array of varied usage, developmental differences, and cultural influences, what definitive criteria can be used to differentiate healthy from pathological narcissism? The time-honored criteria of psychological health—to love and to work—are only partly useful in answering this question. An individual's work history may provide little help in making the distinction. Highly disturbed narcissistic individuals may find extraordinary success in certain professions, such as big business, the arts, politics, the entertainment industry, athletics, and televangelism (Gabbard 1983). In some cases, however, narcissistic pathology may be reflected in a superficial quality to one's professional interests (Kernberg 1970), as though achievement and acclaim are more important than mastery of the field itself.

Pathological forms of narcissism are more easily identified by the quality of the individual's relationships. One tragedy affecting these people is their inability to love. Healthy interpersonal relationships can be recognized by qualities such as empathy and concern for the feelings of others, a genuine interest in the ideas of others, the ability to tolerate ambivalence in long-term relationships without giving up, and a capacity to acknowledge one's own contribution to interpersonal conflicts. People whose relationships are characterized by these qualities may at times use others to gratify their own needs, but this tendency occurs in the broader context of sensitive interpersonal relatedness rather than as a pervasive style of dealing with other people. On the other hand, the person with a narcissistic personality disorder may approach people as objects to be used up and discarded according to his or her needs, without regard for their feelings. People are not viewed as having a separate existence or as having needs of their own. The individual with a narcissistic personality disorder frequently ends a relationship after a short time, usually when the other person begins to make demands stemming from his or her own needs. Most importantly, such relationships clearly do not "work" in terms of the narcissist's ability to maintain his or her own sense of self-esteem.

Phenomenology of Narcissistic Personality Disorder

The psychodynamic literature on NPD is somewhat confusing because the label seems to apply broadly to patients with quite different clinical pictures. DSM-5 (American Psychiatric Association 2013) lists nine criteria for the diagnosis of narcissistic personality disorder (Box 16–1). These criteria identify a certain kind of narcissistic patient—specifically, the arrogant, boastful, "noisy" individual who demands to be in the spotlight. However, they fail to characterize the shy, quietly grandiose, narcissistic individual whose extreme sensitivity to slights leads to an assiduous avoidance of the spotlight (Cooper and Michels 1988).

For many years there was a relatively small literature on narcissistic personality disorder. However, in recent years the literature has expanded to include issues surrounding the constructs of NPD, the assessment and evaluation of patients with the disorder, its epidemiology and etiology, and varying treatment approaches (Campbell and Miller 2011; Ogrodniczuk 2013). There is a broad consensus in this literature that NPD exists on a continuum. In the psychoanalytic literature, one end of the continuum was typified by the envious, greedy individual who demands the attention and acclaim of others, described in detail by Kernberg (1970, 1974a, 1974b, 1998). The person with the type of narcissistic personality disorder that is more vulnerable to slights and self fragmentation was characterized by Kohut (1971, 1977, 1984). These two psychoanalytic authors identified endpoints of the continuum, whereas some patients described by other authors fell somewhere between these two endpoints on the basis of their typical style of interpersonal relatedness.

From a descriptive standpoint, the two opposite extremes on this continuum may be labeled the *oblivious* narcissist and the *hypervigilant* narcissist (Gabbard 1989) (Table 16–1). These terms specifically refer to the person's predominant style of interacting, both in transference relationships with a therapist and in social relationships in general.

Oblivious types appear to have no awareness whatsoever of their impact on others. They talk as though addressing a large audience, rarely establishing eye contact and generally looking over the heads of those around them. They talk "at" others, not "to" them. Persons of this type are oblivious to the fact that they are boring and that some people will therefore leave the conversation and seek companionship elsewhere. Their talk is replete with references to their own accomplishments, and they clearly need to be the center of attention. They are insensitive to the needs of others, even to the point that they do not allow others to contribute to the conversation. These people are often perceived as "having a sender but no receiver." The oblivious type

Box 16–1. DSM-5 Criteria for Narcissistic Personality Disorder

301.81 (F60.81)

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

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of narcissistic personality disorder closely matches the clinical picture described in the DSM-5 criteria.

The narcissistic issues of the hypervigilant type, on the other hand, are manifested in starkly different ways. These people are exquisitely sensitive to how others react to them. In fact, their attention is continually directed toward others, in contrast to the self-absorption of the oblivious narcissist. Like the paranoid patient, they listen to others carefully for evidence of any critical reaction, and they tend to feel slighted at every turn. One narcissistic patient was so attuned to his therapist's reactions that every time the therapist shifted position in his chair or cleared his throat, the patient viewed it as a sign of boredom. When this therapist removed a dead leaf from an office plant on his desk, the patient felt humiliated and demanded a new therapist. Patients of this type are shy and inhibited to the point of being self-effacing. They shun the limelight because they are convinced that they will be rejected

TABLE 16–1. Two types of narcissistic personality disorder patients

Oblivious narcissist	Hypervigilant narcissist
Has no awareness of reactions of others	Is highly sensitive to reactions of others
Is arrogant and aggressive	Is inhibited, shy, or even self-effacing
Is self-absorbed	Directs attention more toward others than toward self
Needs to be the center of attention	Shuns being the center of attention
Has a "sender but no receiver"	Listens to others carefully for evidence of slights or criticisms
Is apparently impervious to having feelings hurt by others	Has easily hurt feelings; is prone to feeling ashamed or humiliated

and humiliated. At the core of their inner world is a deep sense of shame related to their secret wish to exhibit themselves in a grandiose manner.

Shame has other determinants as well. Shame relates to a self-assessment process in which one feels inadequate (i.e., falling short of a standard or ideal of what one should be). Central to shame is a sense of inherent defect (Cooper 1998). Lewis (1987) distinguished shame from guilt. Whereas guilty persons may feel they are not living up to a standard, they do not have the sense of being irreparably defective in the way that certain individuals with narcissistic personality disorder do. The feeling of being humiliated or painfully exposed when confronted with deficiencies in one's abilities or the recognition of unsatisfied needs is central to the psychopathology of individuals with pathological narcissism, and many of the defenses such persons develop are designed to prevent themselves from becoming aware of the feelings associated with these experiences. Steiner (2006) noted that seeing and being seen are central to narcissistic patients, and they struggle with an acute self-consciousness about how they are coming across to others. Particular types of relationships may be protective against this vulnerability to humiliation, but in the context of losing that protection, one can feel extremely conspicuous and exposed to the gaze of others in a devastating and humiliating way.

Although both types struggle with maintaining their self-esteem, they deal with that issue in extremely different ways. Oblivious narcissists attempt to impress others with their accomplishments while insulating themselves from narcissistic injury by screening out the responses of others. Hypervigilant narcissists attempt to maintain their self-esteem by avoiding vulnerable situations and by intensely studying others to figure out how to behave. They projectively attribute their own disapproval of their grandiose fantasies onto others (Gabbard 1983).

Despite the failure of the DSM-5 criteria to represent the hypervigilant variant of narcissistic personality disorder, there is empirical support for the oblivious–hypervigilant distinction. Wink (1991) performed a principal-components analysis of six Minnesota Multiphasic Personality Inventory narcissism scales and found two orthogonal factors: a Vulnerability–Sensitivity dimension and a Grandiosity–Exhibitionism dimension. He concluded that these two relatively uncorrelated sets, which he referred to as *covert* and *overt* narcissism, confirmed the existence of two distinct forms of pathological narcissism. Although both forms shared the features of disregard for others, self-indulgence, and conceit, the Vulnerability–Sensitivity group was characterized as introverted, defensive, anxious, and vulnerable to life's traumas, whereas the Grandiosity–Exhibitionism group was extroverted, self-assured, exhibitionistic, and aggressive. Dickinson and Pincus (2003) also confirmed this distinction and noted the similarities between hypervigilant narcissists and those with avoidant personality disorder.

Further empirical support for the two subtypes of narcissistic personality disorder has come from a study of 701 college students (Hibbard 1992). The subjects filled out questionnaires containing eight scales measuring narcissism, object relations, masochism, and shame. Narcissism formed two distinct subgroups, a narcissistically vulnerable style and a "phallic," grandiose style. The affect of shame was central in dividing these groups—it correlated positively with the vulnerable style and negatively with the grandiose style.

The oblivious or overt narcissist may actually profess happiness as compared with the hypervigilant or covert individual. In a study of 262 undergraduates, Rose (2002) found that overt narcissists score high on traits of grandiosity, entitlement, and exploitiveness, but they also rate themselves high on measures of happiness and self-esteem. In other words, the overt narcissistic personality may actually derive certain psychological benefits from self-deception that ordinary people do not enjoy. Maintaining unrealistic beliefs about themselves, as well as viewing others as inferior, may benefit their overall sense of adjustment to life by defending against pain and shame. The covert type rated themselves as having feelings of inferiority and unhappiness because their defenses against narcissistic wounding are much less developed.

Although these two types may occur in pure form, many patients present with a mixture of phenomenological features from both types. Between these two endpoints on the continuum will be many narcissistic individuals who are much smoother socially and who possess a great deal of interpersonal charm.

A study based on descriptions by clinicians suggested there might actually be three subtypes of NPD (Russ et al. 2008). In this investigation, clinicians used the Shedler-Westen Assessment Procedure-II (SWAP-II) to characterize

patients who they felt were most characteristic of NPD. Twelve hundred psychiatrists and clinical psychologists participated, and a total of 255 patients met DSM-IV criteria for NPD. The authors used a Q-factor analysis to identify three subtypes, which the authors labeled as grandiose/malignant, fragile, and high-functioning/exhibitionistic. They also found that core features of NPD included interpersonal vulnerability, difficulties regulating affect, competitiveness, and underlying emotional distress, all of which are absent from the DSM-5 construct.

The grandiose malignant type, closely aligned with the oblivious narcissist, was characterized by exaggerated self-importance, lack of remorse, interpersonal manipulativeness, seething anger, pursuit of interpersonal power, and feelings of privilege. The fragile category, closely resembling the hypervigilant subtype, warded off painful feelings of inadequacy with grandiosity used defensively and had a powerful undercurrent of inadequate feelings, negative affect states, and loneliness. Finally, the high-functioning variant had an exaggerated sense of self-importance, but these individuals were also outgoing, energetic, and articulate. They apparently had used narcissism as strong motivation to succeed.

Psychodynamic Understanding

The principal controversy surrounding the theoretical understanding of narcissistic personality disorder has revolved around the models of Kohut and Kernberg (Adler 1986; Glassman 1988; Heiserman and Cook 1998; Josephs 1995; Kernberg 1974a, 1974b, 1998; Ornstein 1974a, 1998). Ronningstam (2011) suggested that the major theoretical disagreement among psychoanalytic writers is how the object is represented to the patient. Although Kernberg differentiated the object from the self and suggested a greater degree of internal separateness, self psychologists see the object as an extension of the self that provides missing functions for the patients. Because the self psychology theory of Kohut was covered in some detail in Chapter 2, it is reviewed only schematically here.

Kohut (1971, 1977, 1984) believed that narcissistically disturbed individuals are developmentally arrested at a stage at which they require specific responses from persons in their environment in order to maintain a cohesive self. When such responses are not forthcoming, these individuals are prone to fragmentations of the self. Kohut understood this state of affairs as the result of the parents' empathic failures. Specifically, the parents did not respond to the child's phase-appropriate displays of exhibitionism with validation and admiration, did not offer twinship experiences, and did not provide the child with models worthy of idealization. These failures manifest

themselves in the patient's tendency to form a mirror, twinship, or idealizing transference.

Kohut postulated a double-axis theory (see Figure 2–5 in Chapter 2) to explain how both narcissistic needs and object-related needs can coexist in the same individual. Throughout our lives, Kohut argued, we are in need of selfobject responses from the people around us. In other words, at some level we all regard others not as separate persons but as sources of gratification for the self. A need for the soothing, validating functions of selfobjects is never outgrown. The goal of treatment is to move away from a need for archaic selfobjects toward an ability to use more mature and appropriate selfobjects.

A case example may help illustrate how the theory of self psychology manifests itself in a clinical situation.

> Ms. DD was a 26-year-old single woman who came to treatment after her 4-year relationship with her boyfriend ended. She indicated that his rejection of her had been "devastating." Although she specifically denied any suicidal thoughts, she did say that she felt she was no longer alive without him. Although it had been a year since the breakup, she was unable to get her life back on track. She sat around feeling empty and lonely. She continued to go to work but would return home each evening and just sit in her apartment staring blankly or watching television. Throughout her day at work she felt detached from any activities she pursued, as though she were on "automatic pilot." She repeatedly spoke of needing to be "plugged in" to her boyfriend to feel alive. She desperately missed having him stroke her hair to calm her down when she came home anxious from work. She poignantly stated: "Without him, I am nothing. I can't soothe myself." She lacked the symptoms necessary for a diagnosis of major depressive episode, but she described herself as depressed and empty.
>
> She met with her therapist for several weeks and reported that she began to "feel alive again." Ms. DD then stated that she felt "plugged in" to her therapist. She tended to misinterpret her therapist's comments to mean that he was about to reject her at any moment. She asked if her therapist would increase the number of sessions from two to five a week so she could see him every weekday. The therapist, on the other hand, believed that all he was doing was listening. He noted to his supervisor: "I don't think she is really interested in anything I say. She's perfectly content if I simply give her my undivided attention."

Kernberg's (1970, 1974a, 1974b, 1984, 1998, 2009) theoretical formulations differ sharply from those of Kohut (Table 16–2). The major theoretical differences in their conceptualizations of narcissistic personality disorder may well relate to the different populations of patients that they studied. Kohut's sample consisted of relatively well-functioning outpatients who could afford psychoanalysis. Typically, they were professional people who described vague feelings of emptiness and depression and particular problems in their

TABLE 16–2. Dynamic understanding of narcissistic personality disorder—Kohut versus Kernberg

Kohut	Kernberg
Bases theory on relatively well-functioning people whose self-esteem is vulnerable to slights—all outpatients	Bases theory on a mixture of inpatients and outpatients, most of whom are primitive, aggressive, and arrogant, with haughty grandiosity coexisting with shyness
Differentiates narcissistic personality from borderline states	Defines narcissistic personality as a strikingly similar subcategory of borderline personality (although most have better ego functioning than borderline patients, some function at an overt borderline level)
Does not define inner world of narcissistic personality because emphasis is on internalization of missing functions	Delineates primitive defenses and object relations typical of borderline personality disorder
Defines archaic "normal" self as one that is developmentally arrested	Defines self as a highly pathological structure composed of the fusion of the ideal self, the ideal object, and the real self
Views self as nondefensive	Views grandiose self as being *defensive* against investment or dependency on others
Focuses mainly on libidinal/idealizing aspects, with aggression conceptualized as *secondary* to narcissistic injury	Emphasizes envy and aggression
Accepts idealization at face value as a normal developmental phase making up for missing psychic structure	Views idealization as defensive against rage, envy, contempt, and devaluation

relationships. They struggled to maintain their professional self-esteem, and they tended to feel slighted by others (Kohut 1971). Kernberg, on the other hand, has always worked in academic centers connected with hospitals, and he based his conceptual framework on a mixture of inpatients and outpatients. His clinical descriptions portray patients who are more primitive, more arrogant, more aggressive (often with antisocial features), and more overtly grandiose (although the grandiosity may alternate with shyness) than those depicted by Kohut.

Kohut (1971) differentiated narcissistic personality disorders from borderline conditions. He saw the borderline patient as not having achieved sufficient cohesiveness of the self to be analyzed. His diagnosis of narcissistic personality was based on the development of either the mirror or the idealizing transference in the context of a trial analysis. In contrast, Kernberg (1970) saw the defensive organization of narcissistic personality as strikingly similar to borderline personality disorder. In fact, he viewed it as one of several personality types that operate at a borderline level of personality organization (see Chapter 15). He differentiated narcissistic personality disorder from borderline personality on the basis of the narcissist's integrated but pathological grandiose self. This structure is a fusion of the ideal self, the ideal object, and the real self. This fusion results in the destructive devaluation of object images. Patients with narcissistic personality disorder identify themselves with their idealized self-images in order to deny their dependency on external objects (other people) as well as on the inner images of those objects. At the same time, they deny the unacceptable features of their own self-images by projecting them onto others.

The pathological grandiose self explains the paradox of relatively good ego functioning in the presence of the primitive defenses (splitting, projective identification, omnipotence, devaluation, idealization, and denial) typical of the borderline patient. In other words, whereas borderline patients tend to have alternating self representations that make them look very different from day to day, narcissistic patients have a smoother, more consistent level of functioning based on an integrated pathological self. Also, the borderline personality is much more likely to have problems related to ego weaknesses, such as poor impulse control and poor anxiety tolerance. These ego weaknesses are much less common in narcissistic personalities because of the smooth-functioning self structure. However, Kernberg also added that some narcissistic patients function at an overt borderline level. These patients have the grandiosity and haughtiness of the narcissistic personality with the poor impulse control and the kaleidoscopic object relations of borderline patients. It is this subgroup that occasionally requires hospitalization.

The detailed description of the narcissistic patient's defensive constellation and internal object relations provided by Kernberg is in contrast with Kohut's tendency to leave undefined the inner world of the narcissistic patient. Kohut emphasized the internalization of missing functions from people in the environment and thus was less concerned about the patient's intrapsychic structure. He conceptualized the narcissistic self, however, as an archaic "normal" self that is simply frozen developmentally—in other words, the patient is a child in an adult's body. Unlike Kohut, Kernberg (1974a, 1974b, 2009) viewed the narcissistic self as a highly pathological structure that in no way resembles the normal developing self of children.

He pointed out that the exhibitionistic self-display of children is charming and endearing, in contrast to the greed and demandingness of the narcissist's pathological self.

Another difference in their views of the self relates to the self's defensive functioning. Kohut saw the self as essentially nondefensive (i.e., a normally developing self that simply became stuck). Kernberg saw the pathologically grandiose self as defensive against investment in others and specifically against dependency on others. This characteristic may manifest itself as a pseudo–self-sufficiency whereby the patient denies any need for nurturance while at the same time attempting to impress others and gain approval. Narcissistic patients frequently insist, for example, that they have no reactions to their therapists' vacations.

Kohut's view of the narcissistic personality is perhaps more charitable than Kernberg's. He focused mainly on the childhood longing for certain parental responses. Aggression is seen as a *secondary* phenomenon (i.e., narcissistic rage in reaction to not having one's needs for mirroring and idealizing gratified). In that sense, Kohut viewed aggression as an entirely understandable response to parental failures. Kernberg saw aggression as a more primary factor. Inordinately high levels of aggression cause the narcissistic patient to be destructive toward others. In Kernberg's (1970) view, the etiology of this aggression can be either constitutional or environmental. It was seen, however, as arising from within rather than as simply an understandable reaction to the external failures of others. One manifestation of the narcissistic patient's aggression is chronic intense envy (Kernberg 1974b), which causes the patient to want to spoil and destroy the good things of others. Although Kohut did not view envy as having a central role, Kernberg described these patients as constantly comparing themselves with others, only to find themselves tormented with feelings of inferiority and intense yearning to possess what others have. The devaluation of others to deal with one's envy of them is associated with an emptying out of the internal world of object representations and leaves the patient feeling a sense of an internal void (Kernberg 1998). That emptiness can only be compensated for by constant admiration and acclaim from others and an omnipotent control over others so that their free and autonomous functioning and enjoyment do not create further envy. Kernberg (2009) also emphasizes the syndrome of malignant narcissism, involving more severe superego pathology, some antisocial behavior, and ego-syntonic aggression. There is little capacity for guilt or remorse in these individuals, and they are similar in many respects to individuals with DSM-5 antisocial personality disorders (see Chapter 17).

Idealization was viewed quite differently by Kohut and Kernberg. Kohut viewed idealization in the transference as the recapitulation of a normal developmental phase. Rather than labeling it as a defensive posture, he saw it

as a way to make up for missing psychic structure. Fundamental to Kohut's understanding is the notion that the narcissistic individual is incomplete without a selfobject. Kernberg viewed idealization as a defense against a variety of negative feelings, including rage, envy, contempt, and devaluation.

In light of these point-by-point differences between Kohut and Kernberg, it should be clear that Kernberg was describing patients who more closely approximate the oblivious type, whereas Kohut seemed to be writing about patients who are closer to the hypervigilant type. The narcissistic patients described by Kernberg frequently appear to have nothing but the most superficial forms of object relatedness. If the patient is male, he may have a "Don Juan" syndrome in which he systematically seduces women and discards them when his idealization of them turns to devaluation. Viewing women only as conquests, he has no capacity to empathize with their internal experience. Such a patient seems to have little interest in what others say unless the content is flattering. Although these patients are most commonly male, females may have similar narcissistic pathology.

> Ms. EE was an actress who was extraordinarily charming. She was highly successful as an actress because the charisma she exuded on the stage brought her a great deal of acclaim and applause from her audiences. However, she came to treatment because a series of relationships with men had left her feeling that she would never find anyone who would be suitable for her. She described a rapid loss of interest in each lover after an initial period of idealization. She complained that the men seemed to get preoccupied with their own interests and did not pay enough attention to her. Her last relationship had broken up when her boyfriend exploded at her and said, "No man will ever be able to give you the kind of attention you want. The only place you'll ever see that kind of attention is what a mother gives to a baby!" This comment stung Ms. EE and made her begin to think that psychotherapy would be of help. She was basically describing an inability to mentalize and to appreciate the separate subjectivity of her male lovers along with their needs and interests that did not involve her.

Some observers have speculated that men are more likely to be narcissistic in nature than women because of certain gender stereotypes within the culture. However, an empirical study of 665 college students (Klonsky et al. 2002) found that such assumptions are perhaps not warranted. In this investigation the study subjects who behaved in a way that was consistent with their gender exhibited more narcissistic features, whether or not they were male or female. The authors speculated that there may be masculine and feminine ways of being narcissistic that reflect gender stereotypes within the culture.

The Kohut–Kernberg controversy continues to smolder, with proponents on each side claiming that clinical experience validates their own fa-

vorite theoretical perspective. In practice, some narcissistic patients seem to fit one framework better than the other. The broad range of patients encompassed by the term *narcissistic personality disorder* may demand more than one theoretical perspective for explanation. One research effort to validate the two constructs found data consistent with both theories but suggested that the most parsimonious explanation was to view Kohut's model as a special case of Kernberg's more general ego psychological–object relations theory (Glassman 1988).

The theoretical debate between Kohut and Kernberg often obscures other creative contributions to the understanding of narcissistic personality disorder. The Kleinian view has been elaborated by Rosenfeld (1964) and Steiner (2006). In Rosenfeld's view the most important function of a narcissistic relationship is to maintain the illusory experience that there is no separation between subject and object. Narcissistic individuals deny their dependence and behave as though they are omnipotently self-sufficient. When the object is frustrating, they are disappointed and have intense anxiety about being unable to maintain omnipotent control over the object. Steiner (2006), as noted in the section "Phenomenology of Narcissistic Personality Disorder," believes that being seen and seeing are central to the psychoanalytic understanding of pathological narcissism. In his view humiliation is regarded as particularly unbearable to the narcissistic individual, and patients will try to hide from view to avoid it. They often will look down on the therapist as a way of inflicting humiliation on someone else. Alternatively, they may invite the therapist to join them in looking down on a third party outside the room. These defenses will often break down so that the patient is aware of being seen and feeling that acute sense of exposure with all the accompanying shame and embarrassment.

Rothstein (1980) attempted to understand the narcissistic personality disorder within the framework of Freud's structural model (see Chapter 2). He defined narcissism as "a felt quality of perfection" that is a universal aspect of the human psyche. This perfect state can be integrated with either a healthy or a pathological ego—the nature of the ego determines whether the narcissism is pathological or healthy.

Modell (1976) used the metaphor of a cocoon to describe the narcissistic individual's sense of nonrelatedness to the environment. This cocoon is like an illusion of omnipotent self-sufficiency, reinforced by grandiose fantasies, that may be initiated by a mother who has an exaggerated grandiose view of her child's capabilities. Modell believed that the noncommunicative and nonrelated facade reflects a fear of merger that the patient must defend against. The therapist's task must be to create a holding environment (Winnicott 1965) to allow development to proceed, much as in the treatment of schizoid personality disorders (described in Chapter 14).

Attachment theory can also be applied as a useful conceptual framework. Oblivious narcissists can be regarded as having an impaired capacity to mentalize because they cannot tune in to the mind of another person and understand their impact. Hypervigilant narcissists also experience difficulties with mentalization in that they *misread* the experience of others. Their assumption of narcissistic injury in the comments or behavior of a therapist, for example, is reflective of a failure to see the therapist as having a mind that is separate and distinct from the patient's. Experiences of shame and humiliation may have been traumatic during childhood, so the oblivious narcissist has shut down curiosity about the other person's internal response as a way of avoiding future experiences of feeling shamed. The hypervigilant narcissist, by contrast, tries to maintain an illusion of control over such experiences by *anticipating* them. The flawed mentalizing paradoxically leads to further experiences of humiliation and shame because others feel misunderstood and accused when they are misread.

Many theoretical formulations of narcissistic personality disorder are "parent blaming." Self psychology, for example, emphasizes the empathic failures of the parent. In popular culture, there is an alternative view of the parent as excessively indulgent. Kernberg stressed parental coldness and strictness in the histories of narcissistic personality disorders. Horton (2011) has evaluated the various theories of parental involvement, and he emphasizes the relative lack of persuasive evidence for a specific parenting style as pathogenic. Some studies suggest that there is a significant genetic component to narcissism (Vernon et al. 2008). Hence, one must consider the possibility that parents are *reacting* to particularly difficult traits in their children, thus understanding parent-child difficulties as bidirectional. The exact nature of the role that the parents play remains unclear and requires further study. However, as a clinician, one must be wary of assuming that the patient's report of the parent is a truly objective account. The transference-countertransference developments in the treatment may illuminate aspects of the parent-child conflict in a way that a narrative historical account cannot.

Treatment Approaches

Individual Psychotherapy and Psychoanalysis

Technique

Both Kernberg and Kohut believed that psychoanalysis is the treatment of choice for most patients with narcissistic personality disorder. Because of practical limitations of time and money, many of these patients are seen in expressive-supportive psychotherapy with a predominance of expressive

techniques in once- or twice-weekly sessions. The specific technical suggestions of Kohut and Kernberg reflect their different theoretical conceptualizations.

For Kohut, empathy was the cornerstone of the technique (Ornstein 1974b, 1998). Treaters must empathize with the patient's attempt to reactivate a failed parental relationship by coercing the therapist into meeting the patient's need for affirmation (the mirror transference), for idealization (the idealizing transference), or for being like the therapist (the twinship transference). The emergence of these selfobject transferences should not be prematurely interpreted. Kohut's emphasis on empathizing with the patient as a victim of the empathic failures of others does not imply a predominantly supportive technique. He stressed that the analyst or therapist should interpret—rather than actively gratify—the patient's yearning to be soothed (Kohut 1984). A typical intervention might sound like this: "It hurts when you are not treated the way you feel you deserve to be treated."

Despite Kohut's insistence that his technical approach did not depart radically from classical psychoanalytic technique, his suggestions as described by supervisees (Miller 1985) revealed fundamental differences from that technique. He advised analysts to always take analytic material in a "straight" manner, just as the patient experiences it. The therapist can thus avoid repeating the empathic failures of the parents, who often try to convince a child that his or her actual feelings are *different* from those the child describes. Kohut indicated that, if the face-value approach does not bear fruit, one could always invert material or look for hidden meanings beneath the "experience-near" feelings. This approach is intimately related to Kohut's view of "resistance" as a psychic activity that safeguards the cohesiveness of the self (see Chapter 2).

Kohut was acutely sensitive to evidence of a patient's self-fragmentation in the actual analytic or therapeutic session. When such fragmentations occur, the therapist must focus on the precipitating event rather than on the content of the fragmentation itself (Miller 1985; Ornstein 1974a). For example, after one of Kohut's supervisees sneezed in an analytic session and the patient found it difficult to continue, Kohut advised the analyst to focus on the naturalness of the patient's response to such an unexpected stimulus rather than on the patient's special sensitivity to the stimulus (Miller 1985). This focus is in keeping with a general premise of self psychology that therapists must be continually attuned to how they recapitulate infantile traumas with their patients. Kohut believed that the patient is always right; if the patient feels deflated or hurt, it is reasonable to assume that the analyst or therapist has made an error. He noted that patients frequently feel exposed and ashamed when the analyst calls attention to slips of the tongue, so he did not stress the interpretation of parapraxes. Kohut was always sensitive

to the proneness of narcissistic patients to feel shame. The therapist must avoid bypassing the patient's conscious subjective experience to address unconscious material outside the patient's awareness. Interpretations of unconscious motives will only make the patient feel "caught," misunderstood, and ashamed.

Kohut stressed the importance of looking at the *positive* side of the patient's experience, and he scrupulously avoided comments that might be viewed as harshly critical. He called attention to the patient's progress and shunned the asking of questions. He believed that it was the therapist's job to understand, not the patient's (Miller 1985).

Kohut asserted that the goal of psychoanalytic and psychotherapeutic treatment of narcissistic personality disorder is to help the patient identify and seek out appropriate selfobjects. Kohut believed that mental health professionals tend to overvalue separation and autonomy. He was concerned that therapists might use a moralistic tone to convey to patients the expectation that they *should* become more independent.

Kohut's technical approach has been criticized on many counts. His reduction of all psychopathology to empathic failures on the part of parents has been criticized as oversimplified "parent blaming" and as being out of keeping with the core psychoanalytic principle of overdetermination (Curtis 1985; M.H. Stein 1979). His emphasis on staying "experience near" in the therapeutic technique has also been challenged as having the potential to overlook important unconscious issues that should be addressed during treatment (Curtis 1985). Finally, Kohut's tendency to regard rage as a product of the disintegration of the self may underestimate the role played by internal conflict (Cohen 2002).

Kernberg (1974a, 1974b) observed some of the same transference phenomena as Kohut, but he believed that different technical approaches are indicated. For example, he conceptualized the mirror and idealizing transferences in a more parsimonious manner (Table 16–3). Kernberg saw the patient's grandiose self as being alternately projected and reintrojected so that one idealized figure is always in the room while the other figure is devalued and in the shadow of the idealized person. He also viewed idealization as a frequent defensive operation that involves splitting. In other words, because idealization of the therapist may be the patient's way of defending against split-off feelings of contempt, envy, and rage, the therapist should interpret idealization as a defense rather than simply accepting it as a normal developmental need, as Kohut advocated.

Kernberg's approach in general is much more confrontational than Kohut's. Convinced that the greed and demandingness typical of the narcissistic personality disorder are not simply aspects of normal development, Kernberg believed that these traits must be confronted and examined from

TABLE 16–3. Psychotherapeutic technique—Kohut versus Kernberg

Kohut	Kernberg
Views mirror and idealizing transferences as two different poles of bipolar (Kohut 1977) or tripolar (Kohut 1984) self	Views mirror and idealizing as aspects of transference related to projection and reintrojection of patient's grandiose self
Accepts idealization of patient as normal developmental need	Interprets idealization as a defense
Empathizes with patient's feeling as an understandable reaction to failures of parents and others	Helps patient see his or her own contribution to problems in relationships
Accepts patient's comments at face value, viewing resistances as healthy psychic activities that safeguard the self	Confronts and interprets resistances as defensive maneuvers
Looks at the positive side of patient's experience	Examines both positive and negative aspects of patient's experience (if only positive experiences are emphasized, the patient may develop an increased fear of internal envy and rage)
Calls attention to patient's progress	Focuses on envy and how it prevents patient from acknowledging and receiving help
Has treatment goal of helping patient acquire ability to identify and seek out appropriate selfobjects	Has treatment goal of helping patient to develop guilt and concern and to integrate idealization and trust with rage and contempt

the standpoint of their impact on others. Whereas Kohut emphasized the positive side of the patient's experience, Kernberg believed that early negative transference developments must be systematically examined and interpreted. Specifically, Kernberg stressed that the therapist must focus on envy and how it prevents the patient from receiving or acknowledging help. When patients receive something positive from their therapist, it often escalates their envy because it generates feelings of inadequacy or inferiority in response to the therapist's capacity for nurturing and understanding. A sample interpretation might sound like this: "To avoid painful feelings of envy, you may need to dismiss my comments as being ridiculous or meaningless." Kernberg (2009) noted that narcissistic patients are often intensely competitive with the therapist and cannot conceive of the notion that the therapist is genuinely interested in and concerned about them. Hence, they fear de-

pendency and defend against it with attempts to omnipotently control the treatment.

Although Kernberg is often misconstrued as focusing exclusively on negative transference, he in fact advocated a systematic examination of both positive and negative transference developments (Kernberg 1974b). He warned that therapists who address only the positive aspects of the transference may unconsciously increase their patients' fear of their own envy or rage. A patient who believes that the therapist cannot handle those aspects of the patient may therefore split them off and keep them outside the therapeutic process.

Kernberg also differs significantly from Kohut in important ways regarding the goals of treatment. Whereas Kohut's technique implies that the essence of the cure is not in the cognitive sphere, Kernberg believed that a cognitive understanding via the interpretive process is crucial to therapeutic success. The goal of treatment for Kernberg (1970) included developing guilt and concern for others as well as integrating idealization and trust with rage and contempt (i.e., integrating the "good" aspects of experience with the "bad").

Kernberg viewed persons with narcissistic personality disorder as among the most difficult patients to treat because much of their effort goes into trying to defeat the therapist. For the treatment and the therapist to be effective, these patients must deal with their intense feelings of competitiveness and envy that someone else has good qualities that they lack. Kernberg believed that for the treatment to be viable, these defensive maneuvers must be continually confronted. A patient with significant antisocial features (which are common in narcissistic patients) may simply be untreatable. (The factors that determine the treatability of antisocial patients are discussed in Chapter 17 in some detail.) However, several factors suggest a favorable prognosis (Kernberg 1970): some ability to tolerate depression and mourning, more guilt than paranoid tendencies in the transference, some ability to sublimate primitive drives, relatively good impulse control, and good motivation. Patients who seek therapy or analysis simply for training purposes or because they think it will confer prestige on them in the eyes of others may present a formidable resistance that contributes to a less favorable prognosis.

In the subgroup of patients just mentioned who operate at an overtly borderline level, Kernberg (1984) suggested that a truly supportive psychotherapy is a much more effective treatment than expressive therapy or analysis. This approach should probably be combined with inpatient treatment if the ego weaknesses, such as lack of impulse control, are particularly severe. The indications for supportive therapy in narcissistic personality disorders include excessive cruelty and sadism, prominent antisocial features, virtually no involvement with other people, intense paranoid reactions to

others, and a proneness to chronic rage that is always rationalized as someone else's fault. In these supportive processes, Kernberg (1984) suggested that patients may benefit from "stealing" positive qualities from their therapist. Because this identification with the therapist may help patients function better, the process is best left uninterpreted.

Critics of Kernberg's approach argue that it interferes with the natural development of selfobject transferences. Some have even suggested that aggressively confronting the oral aggression of patients may result in their deteriorated functioning (Brandschaft and Stolorow 1984). In this view, the borderline picture of rage, contempt, and devaluation is an artifact of the narcissistic injury induced by the therapist's "critical interventions." Thus the differences in the kinds of patients described by Kernberg and Kohut could be viewed as partially resulting from iatrogenic factors (Adler 1986).

Psychotherapists faced with the formidable task of treating narcissistic patients must avoid an "either/or" approach to the theories of Kernberg and Kohut. Rather than obsessing about which one is "right," therapists may more usefully apply themselves to listening carefully to their patients, observing the transference and countertransference developments, and particularly noting their responses to trial interventions. In this manner therapists will soon reach a tentative conclusion about which theoretical and technical model is the most helpful with the particular patient under consideration. Some patients will simply not tolerate anything but an empathic, experience-near approach based on Kohut's model. Any deviation from that pattern of interventions will be met with prolonged "shutdowns," with the patient refusing to talk and feeling misunderstood or even abruptly deciding to quit therapy. In other cases, the patient may feel understood by interpretations of envy and contempt and may therefore respond better to Kernberg's technique. Some narcissistic patients do not develop any of the selfobject transferences Kohut described but instead present the therapist with continual devaluation and rage. In some instances, the therapist must interpret and confront these overt verbal attacks or the patient will find it difficult or impossible to persist in the treatment. Mitchell (1988) pointed out that it is erroneous to regard Kohut's approach as more empathic than Kernberg's. Both respond empathically to different dimensions of the patient.

Still other patients can benefit from a combination of technical strategies. Although purists would argue that the two theories are incompatible, the patient is usually not aware of theories. Moreover, the therapist treats patients, not theories. Many patients require the self psychological approach to technique early in their treatment because it helps build a therapeutic alliance based on a sense that the therapist understands and empathizes with the experience of victimization. Indeed, building a therapeutic alliance is a formidable challenge with patients who have NPD. They dread facing their

own imperfections and humiliating exposure and have a limited ability to self-disclose because of these fears (Ronningstam 2014). They may also expect that the therapist is going to blame them or devalue them in a way that makes them feel worthless and incompetent. In addition, they may be highly defended against seeing their character traits as problematic. In some cases, they have relationships that maintain their self-esteem so that they are convinced that they are functioning well. Alliance building can be operationalized by identifying goals that therapist and patient can agree on and by acknowledging that accomplishing those goals may result in wounds to the patient's self-esteem and exposure of vulnerability.

After an alliance is established, the therapist may begin to confront patients with their own contributions to their interpersonal difficulties, such as inordinate expectations that others cannot fulfill. Practically speaking, narcissistic pathology can rarely be conceptualized as wholly the fault of either the parents or the patient. More commonly, both parties have contributed to the difficulty, and a comprehensive therapy should address these problems from both angles. Indeed, the majority of analysts and other dynamically oriented clinicians operate from some midpoint between the two extremes (Gabbard 1998; Mitchell 1988). Josephs (1995) suggested that although empathy for the patient's archaic selfobject needs is helpful initially, it ultimately must be counterbalanced by interpretation of the defensive function of the selfobject transferences.

From a mentalization-based model, therapists might help the patient by using some of the strategies described in Chapter 15 with borderline patients. Research suggests that persons with the NPD diagnosis have difficulties with empathic capacity and therefore can benefit from help with mentalizing the experience of others (Ritter et al. 2011). Emphasis would be on promoting a sense of secure attachment with hypervigilant patients so their state of arousal would drop to a level more conducive to reflection (Allen 2003). With both oblivious and hypervigilant patients, therapists might wish to explore the patient's fantasy of the therapist's internal state. With oblivious patients, in particular, therapists would encourage them to become more curious about how their behavior and comments affect others. Other useful techniques are to identify feelings in the patient and ask these patients if there are other possibilities that might be entertained when they are convinced that they know the therapist's mind.

Finally, we must not assume that the etiology and pathogenesis of narcissistic character pathology will always fit neatly into the theoretical frameworks of Kohut and Kernberg. As noted previously in the section "Psychodynamic Understanding," there may be genetic or constitutional features of the patient that make it difficult for parents to manage the demands of the child. Their failures of empathy may therefore relate to the heritable

traits of the child rather than inherently negative aspects of the parent. In sharp contrast to the parent with empathic failures, some parents of narcissistic patients tend to be overly indulgent. They seem to encourage grandiosity through a pattern of excessive mirroring. Such parents shower their children with admiration and approval, making them feel truly special and gifted. When these children grow up, they are repeatedly shattered because others do not respond to them as their parents did.

In other cases, mother–son incest or variants thereof may produce a narcissistic picture of the hypervigilant type (Gabbard and Twemlow 1994). These patients have a grandiose view of themselves as entitled to occupy a special position with others, combined with a paranoid tendency to anticipate retaliation or abandonment for perceived oedipal transgressions. Hence, therapists can benefit from taking an open-minded approach with narcissistic patients; the therapy should be a collaborative effort in which patient and therapist together discover the origins of the patient's difficulties without rigidly forcing the material to fit one theory or another.

Countertransference

Regardless of a therapist's theoretical framework, certain predictable countertransference problems arise in the treatment of narcissistic patients (Gabbard 2013). Some of these problems are of sufficient magnitude and intensity to undermine the treatment situation irrevocably. Hence, the optimal management of countertransference patterns cannot be stressed enough.

Because countertransference is inextricably tied to transference, a review of the narcissistic transferences may help us anticipate many of the countertransference problems that occur with narcissistic personality disorders. Table 16–4 summarizes the principal narcissistic transferences.

There is little question that psychotherapy as a career provides an opportunity to gratify wishes to be loved, needed, and idealized (Finell 1985). Narcissistic issues are not the exclusive province of the narcissistic personality disorder. These issues reside in all patients and in all therapists. Therapists who cannot acknowledge and accept their own narcissistic needs, and then harness them in the service of delivering effective treatment, may instead disavow and externalize them. These defenses contribute to an erroneous view of the patient as the sole carrier of narcissism in the patient–therapist dyad.

Another countertransference problem that regularly surfaces in the treatment of narcissistic patients is boredom. This usually arises from a feeling that the patient is unaware of or oblivious to the therapist's presence. For prolonged periods, the therapist may have to tolerate a sense of being used

TABLE 16–4. Varieties of narcissistic transference

Need for admiration and affirmation from the therapist
Idealization of the therapist
Assumption of twinship between therapist and patient
Proneness to feel shamed and humiliated by the therapist
Contempt and devaluation toward the therapist, often related to envy
Denial of the therapist's autonomy
Omnipotent control of the therapist
Insistence on exclusive dyadic relatedness that does not allow for a third party
Use of the therapist as a sounding board without empathy for the therapist's experience
Denial of dependency on the therapist
Inability to accept help from the therapist

as a sounding board by the patient. This pattern is particularly typical of the oblivious narcissistic patient who holds forth as though speaking to an audience, ignoring the therapist as a separate person with separate thoughts and feelings.

Mr. FF came to therapy after three previously failed attempts. His last treatment had lasted 3 years with a therapist in another city. Mr. FF denigrated that therapeutic experience as "a complete waste of time" and could not even recall his previous therapist's name. (These two signs, an inability to remember a previous therapist's name and a complete devaluation of the previous therapeutic experience, are often diagnostic clues to narcissistic character pathology.) He said that "doctor what's his name" interrupted him a lot and was not a good listener. Mr. FF talked at great length about his need for a really "special" therapist. He even speculated that there might not be anyone in the city who could really understand him.

As Mr. FF continued to ramble on at some length over many weeks, his therapist began to dread each session. The therapist found his thoughts wandering to his plans for the evening, his financial status, unfinished paperwork, and a variety of other matters with little bearing on Mr. FF and his problems. The therapist also found himself glancing at the clock more often than usual, eagerly awaiting the end of Mr. FF's session. When the therapist intervened, Mr. FF would often ignore his comments and say, "Just let me finish this train of thought first," or, "Oh, yes, I'm already aware of that."

After returning from a 3-week vacation, the therapist resumed his sessions with Mr. FF. In the first session, the patient picked right up where he had left off at the end of their last session, as though no time had elapsed. The therapist, exasperated by his sense that he had no importance whatsoever to Mr. FF, said, "You act as though we saw each other yesterday. Didn't the 3-week separation from me have any impact on you?" Mr. FF detected a

critical, sarcastic tone in the therapist's voice and replied, "You have the same problem as my last therapist. You're always inserting yourself into this. I'm not paying you to talk about you or your feelings. I'm here to talk about myself."

All of us have a need to be needed, and it is therefore difficult for therapists to tolerate the "satellite existence" (Kernberg 1970) that many narcissistic patients assign them. This feeling of being excluded by the patient may represent a projective identification process (Adler 1986; Finell 1985) in which the patient excludes the therapist just as he was once excluded by his own parents. Because the narcissistic patient tends to treat the analyst as a self-extension, the patient is likely to evoke certain states in the analyst that reflect the patient's own internal struggles (Groopman and Cooper 2001). In other words, an aspect of the patient is projected onto the therapist, who identifies with that self before helping the patient to reintroject it. The containment of this projected aspect of the patient may be a major part of the psychotherapeutic treatment in narcissistic patients. Understanding this pattern may keep the therapist from withdrawing from the patient, from sadistically confronting the patient, or from feeling hurt and abused by the patient.

The hypervigilant variety of narcissistic personality leads the therapist to struggle with countertransference problems of feeling controlled. When the patient reads every movement as an indication of boredom or rejection, the therapist may feel coerced into sitting still and into focusing attention on the patient every moment. Interventions designed to address this interaction may deal productively with this countertransference development. A therapist working from Kernberg's perspective might say: "You seem to have an unrealistic expectation that you can control others and make them behave as extensions of yourself rather than allowing them to respond from within according to their own needs." A self psychological intervention might consist of "It seems to hurt your feelings when I clear my throat or fidget in my seat because you feel I am not giving you my full attention." Regardless of the pros and cons of these two sample interventions, the main point is that such comments bring a behavioral interaction associated with a countertransference response into the verbal realm, where it can be discussed openly as an issue between therapist and patient.

The therapist will often have to struggle with countertransference feelings in response to intense devaluation by the patient.

Ms. GG was a narcissistic patient functioning at an overtly borderline level who had been hospitalized for drug abuse. She demanded barbiturates for insomnia and became enraged when her hospital doctor refused to prescribe them. Each time the doctor made daily rounds, Ms. GG would recite her doc-

tor's many shortcomings: "You're only a resident, so you don't understand how to relate to patients. When you try to go into practice after your residency, you won't have any patients because you don't know how to relate to people. Instead of listening to my needs, you practice psychiatry out of a book. You don't even know how to dress. You're a complete joke as a physician." The doctor asked, "Why is it that you feel such hatred for me?" Ms. GG responded, "Hatred? You're not worth hating! You're beneath contempt!"

These verbal barrages are all too common with narcissistic patients. When they go on at some length, the doctor feels useless and impotent, as well as hurt and angry. These patients engender strong countertransference hatred that can lead to vengeful comments or ill-advised management decisions as a way to get back at the patient. Although as therapists we can contain a certain amount of abuse, we all have a limit that only we can determine. When that line is crossed, the therapist may need to confront the patient's contempt forcefully by pointing out how the barrage is destroying the patient's chance of getting effective treatment.

The patient's narcissistic transferences can trigger latent conflicts within the therapist in such a way that countertransferences that are usually dormant come to the surface. Cohen (2002), for example, described how he began to feel that his patient's dismissal of him was justified. Feelings of insecurity and insufficiency long present in the therapist are triggered by the patient's attitude of pseudo self-sufficiency. Moreover, therapists must be aware of how their own desires for the patient to behave in a particular way may reinforce narcissistic resistances (Gabbard 2000; Wilson 2003). Our apparent altruism in trying to help people with emotional difficulties always has an undercurrent of self-interest (Gabbard 2000). We go to work day after day with the hope of gratifying a wish for a specific form of object relationship involving a selfless devoted helper and an appreciative patient who acknowledges having been helped. The ungrateful narcissistic patient may thwart the development of this wished-for relationship by the therapist and leave the therapist to give subtle or not-so-subtle messages to patients that they should be different than they are in their approach to the therapy. Patients are then put in the role of having to deal with the therapist's wishes to have a "good" patient and a "good" therapy process. This pressure from the therapist can reinforce the patient's narcissistic resistances (Wilson 2003). Because some material that patients with narcissistic personality disorder present is difficult to tolerate, therapists may tune out the narcissistic patient, stop listening, provide facile interpretations to get the patient to change the subject, or send other messages about the unacceptability of what the patient is expressing. Like others, therapists may feel that they are being sucked dry of all they have to give and then discarded after the patient is through with them. The experience of being used in this way may chal-

lenge the patience of the most tolerant therapist, and many of us will make efforts to engage the patient at a different level to avoid leaving the office with this feeling.

Finally, one other form of countertransference emerges with a particularly charming or entertaining narcissistic patient. Russ et al. (2008) reported a third subtype of NPD that they characterized as a high-functioning individual who is relatively successful in his or her field. Such patients may actually produce feelings of envy and admiration in the therapist such that therapists find themselves "enjoying the show" rather than working therapeutically to help the patient (Gabbard 2013). In such circumstances, the fact that he or she is being treated as an extension of the patient's self may go unnoticed by the therapist, who is simply meeting the needs of the patient for affirmation and validation. Such therapies can become stalemated in a mutual admiration society in which patient and therapist compliment one another.

Group Psychotherapy

Dynamic group psychotherapy for patients with narcissistic personality disorder is fraught with difficulties if it is the only treatment used (Azima 1983; Horner 1975; Wong 1979, 1980; Yalom 1985). Piper and Ogrodniczuk (2005) note that the hunger for admiration, sense of entitlement, and lack of empathy may alienate others. Dropout rates are high with narcissistic patients as a result. Oblivious narcissistic patients may enjoy the idea of having an audience in group psychotherapy, but they may also resent the fact that other people take some of the therapist's time and attention. One such patient quit group therapy because he never got enough "air time." The hypervigilant narcissistic patient may be injured at even the suggestion of group therapy. The referral itself is experienced as a rejection or as an indication that the therapist is not interested in the patient. Most narcissistic patients will see group psychotherapy as a situation in which their specialness and uniqueness will be overlooked. Narcissistic patients tend to place extraordinary stress on the group therapist because of their need for narcissistic gratification from the group (Roth 1998). When narcissistic patients do enter group therapy, they often monopolize the group discussions or take on the role of "doctor's assistant," making observations about other people's problems but denying their own (Wong 1979).

Despite the problems inherent in group settings for narcissistic patients, there are clearly some advantages. In groups, narcissistic patients must confront and accept the fact that others have needs and that they themselves cannot expect to be the center of attention at all times. Moreover, narcissistic patients may also benefit from the feedback that others provide about the im-

pact of their character traits on others. Narcissistic patients can have therapeutic effects on others in the group by activating latent feelings of envy and greed in patients with other forms of characterological disturbance (Azima 1983).

Some authors have suggested that combined individual and group psychotherapy may benefit narcissistic patients more than either approach alone (Horwitz 1977; Wong 1979, 1980). Few groups can absorb the narcissistic patient's intense demands for attention, but if an individual process is begun first, the patient may make fewer demands on the group. Wong (1979, 1980) specifically recommended a rather long preparatory period of individual therapy with a technical approach along the lines described by Kohut so that a solid therapeutic alliance exists by the time the patient enters the group. This preparatory period also gives the patient time to explore personal fantasies about group psychotherapy. Wong recommended using the same therapist for both individual and group psychotherapy. Even with the combination, however, the therapist must actively support the patient if the other group members begin to scapegoat the narcissistic member. The group therapist can help the other patients empathize with the narcissistic patient's need to be recognized and admired.

As discussed in Chapter 5, group psychotherapy can serve to dilute intense negative transferences. This principle is certainly applicable to narcissistic patients, and the other patients in the group are often helpful in pointing out the distortions involved in devaluing or idealizing the therapist. Similarly, the countertransference reactions that are so problematic in the treatment of narcissistic patients can also be diluted in group therapy (Wong 1979). However, it is advisable to have only one narcissistic patient at a time in a heterogeneous group, lest the impact of these patients' demandingness overwhelm the other members.

Narcissistic Personality Disorder Over the Life Cycle

Narcissistic patients who come to treatment as young adults often complain about the quality of their intimate relationships. They may have had repeated infatuations that are short-lived and unsatisfying. After the initial luster of the relationship wears off, idealization of the partner turns either to devaluation or to boredom, and they withdraw and seek new partners who can fulfill their needs for admiration, affirmation, unconditional love, and perfect attunement. This pattern of sucking people dry and discarding the empty shells may eventually become tiresome. These patients may settle down and marry in their 30s or 40s.

Not surprisingly, characteristic patterns of difficulty occur in the marriages of patients with narcissistic personality disorder. They may first seek marital

therapy under the guise of sexual problems, depression, or impulsive behavior (Lansky 1982). Beneath the disguised presentation is often a dread of being shamed or humiliated by the marital partner (i.e., a fear of self-fragmentation, in self psychological terms). A narcissistic husband, for example, may blame his wife for deliberately trying to humiliate him rather than acknowledging that he has a problem with being excessively vulnerable, dependent, and extraordinarily needy of selfobject responses, such as mirroring, from his wife. This same husband may eventually reach a state of chronic narcissistic rage, in which he maintains an intractable resentment and bitterness toward his wife for not treating him in the manner to which he feels entitled. Such marriages may be highly refractory to marital therapy because the narcissistic spouse perceives the injury as so damaging that forgiveness is out of the question and nothing the offending spouse can do could possibly redress the grievances.

Regardless of whether narcissistic patients choose to marry as they travel through life, they are likely to find the aging process highly distressing. In many cases these patients are physically attractive or interpersonally charming and have achieved a certain degree of success during their young adult years. As the Rose (2002) study suggested, oblivious types may even be relatively happy if life circumstances have been good. However, although they can postpone facing the emptiness at their core, they cannot ultimately escape it. As Kernberg (1974b) noted,

> If we consider that throughout an ordinary life span most narcissistic gratifications occur in adolescence and early adulthood, and that even though the narcissistic triumphs and gratifications are achieved throughout adulthood, the individual must eventually face the basic conflicts around aging, chronic illness, physical and mental limitations, and above all, separations, loss, and loneliness—then we must conclude that the eventual confrontation of the grandiose self with the frail, limited, and transitory nature of human life is unavoidable. (p. 238)

Many narcissistic patients do not age well. Their grandiose fantasies of unending youth and beauty are torn asunder by the vicissitudes of aging. To prove their youth and vigor, they may frantically seek extramarital affairs with partners half their age or take on ill-advised pursuits such as marathon running. Also common are dramatic religious conversions in which the narcissist avoids mourning by a manic flight into the shadow of an idealized object (God).

Much of the pleasure of midlife and old age involves vicarious enjoyment of the success of younger people, such as one's children (Kernberg 1974b). One of the tragedies facing persons with narcissistic personality disorder is that they are robbed of this source of pleasure because of their envy and de-

spair. These feelings may bring patients to treatment for the first time when they are well into their 40s. Faced with a sense of having missed something and the feeling that their lives are on a faulty course, they may finally be amenable to treatment. They often find themselves lonely, without any supportive relationships, and with a devastating feeling of being unloved. They see themselves confirming the warning of Benjamin Franklin: "He who loves himself will have no rivals."

Some patients with high levels of pathological narcissism may respond favorably to certain life events, so there is reason for hope. Ronningstam et al. (1995) reported on changes in narcissism over a 3-year period in a follow-along study of 20 patients with narcissistic personality disorder. Although 40% remained unchanged, 60% showed significant improvement. Examination of life events for the improved patients suggested that three types of experiences had made a difference in their narcissistic orientation. For nine subjects, *corrective achievements* had occurred, leading to an enhanced acceptance of a more realistic self-concept along with a diminution of exaggerated fantasies. For four of the patients, a *corrective relationship* had been instrumental in reducing pathological narcissism. This observation led the investigators to conclude that some narcissistic defenses are not as entrenched as they appear to be in certain individuals who are diagnosed with narcissistic personality disorder. Finally, in three of the patients *corrective disillusionments* occurred that helped the patients gain a more realistic assessment of themselves.

Narcissistic patients provide enormous challenges for therapists. The effort is worthwhile, however, because even if only partially successful, it will help attenuate the ravages of the second half of life. If, through treatment, narcissistic patients can achieve some degree of empathy, can partially replace their envy with admiration, and can begin to accept others as separate individuals with their own needs, then they may be able to avoid ending their lives in embittered isolation.

References

Adler G: Psychotherapy of the narcissistic personality disorder patient: two contrasting approaches. Am J Psychiatry 143:430–436, 1986

Allen JG: Mentalizing. Bull Menninger Clin 67:91–112, 2003

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Azima FJC: Group psychotherapy with personality disorders, in Comprehensive Group Psychotherapy, 2nd Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, MD, Williams & Wilkins, 1983, pp 262–268

Brandschaft B, Stolorow R: The borderline concept: pathological character or iatrogenic myth? in Empathy II. Edited by Lichtenberg J, Bornstein M, Silver D. Hillsdale, NJ, Analytic Press, 1984, pp 333–357

Campbell WK, Miller JD (eds): The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings, and Treatments. Hoboken, NJ, Wiley, 2011

Cohen DW: Transference and countertransference states in the analysis of pathological narcissism. Psychoanal Rev 89:631–651, 2002

Cooper AM: Further developments in the clinical diagnosis of narcissistic personality disorder, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 53–74

Cooper AM, Michels R: Book review of Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM-III-R by the American Psychiatric Association). Am J Psychiatry 145:1300–1301, 1988

Curtis HC: Clinical perspectives on self psychology. Psychoanal Q 54:339–378, 1985

Dickinson KA, Pincus AL: Interpersonal analysis of grandiose and vulnerable narcissism. J Pers Disord 17:188–207, 2003

Finell JS: Narcissistic problems in analysts. Int J Psychoanal 66:433–445, 1985

Gabbard GO: Further contributions to the understanding of stage fright: narcissistic issues. J Am Psychoanal Assoc 31:423–441, 1983

Gabbard GO: Two subtypes of narcissistic personality disorder. Bull Menninger Clin 53:527–532, 1989

Gabbard GO: Transference and countertransference in the treatment of narcissistic patients, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 125–146

Gabbard GO: On gratitude and gratification. J Am Psychoanal Assoc 48:697–716, 2000

Gabbard GO: Countertransference issues in the treatment of pathological narcissism, in Understanding and Treating Pathological Narcissism. Edited by Ogrodniczuk JS. Washington, DC, American Psychological Association, 2013, pp 207–217

Gabbard GO, Twemlow SW: The role of mother–son incest in the pathogenesis of narcissistic personality disorder. J Am Psychoanal Assoc 42:159–177, 1994

Glassman M: Kernberg and Kohut: a test of competing psychoanalytic models of narcissism. J Am Psychoanal Assoc 36:597–625, 1988

Groopman L, Cooper AM: Narcissistic personality disorder, in Treatments of Psychiatric Disorders, 3rd Edition, Vol 2. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2001, pp 2309–2326

Heiserman A, Cook H: Narcissism, affect, and gender: an empirical examination of Kernberg's and Kohut's theories of narcissism. Psychoanalytic Psychology 15:74–92, 1998

Hibbard S: Narcissism, shame, masochism, and object relations: an exploratory correlational study. Psychoanalytic Psychology 9:489–508, 1992

Horner AJ: A characterological contraindication for group psychotherapy. J Am Acad Psychoanal 3:301–305, 1975

Horton RS: Parenting as a cause of narcissism: empirical support for psychodynamic and social learning theories, in The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings, and Treatments. Edited by Campbell WK, Miller JD. Hoboken, NJ, Wiley, 2011, pp 181–190

Horwitz L: Group psychotherapy of the borderline patient, in Borderline Personality Disorders: The Concept, the Syndrome, the Patient. Edited by Hartocollis PL. New York, International Universities Press, 1977, pp 399–422

Josephs L: Balancing Empathy and Interpretation: Relational Character Analysis. Northvale, NJ, Jason Aronson, 1995

Kernberg OF: Factors in the psychoanalytic treatment of narcissistic personalities. J Am Psychoanal Assoc 18:51–85, 1970

Kernberg OF: Contrasting viewpoints regarding the nature and psychoanalytic treatment of narcissistic personalities: a preliminary communication. J Am Psychoanal Assoc 22:255–267, 1974a

Kernberg OF: Further contributions to the treatment of narcissistic personalities. Int J Psychoanal 55:215–240, 1974b

Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984

Kernberg OF: Pathological narcissism and narcissistic personality disorder: theoretical background and diagnostic classification, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 29–51

Kernberg OF: Narcissistic personality disorder, in Psychodynamic Psychotherapy for Personality Disorders: A Clinical Handbook. Edited by Clarkin JF, Fonagy P, Gabbard GO. Washington, DC, American Psychiatric Publishing, 2009, pp 257–287

Klonsky ED, Jane JS, Turkheimer E, et al: Gender role and personality disorders. J Pers Disord 16:464–476, 2002

Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York, International Universities Press, 1971

Kohut H: The Restoration of the Self. New York, International Universities Press, 1977

Kohut H: How Does Analysis Cure? Edited by Goldberg A. Chicago, IL, University of Chicago Press, 1984

Lansky MR: Masks of the narcissistically vulnerable marriage. International Journal of Family Psychiatry 3:439–449, 1982

Lasch C: The Culture of Narcissism: American Life in an Age of Diminishing Expectations. New York, WW Norton, 1979

Lewis HB (ed): The Role of Shame and Symptom Formation. Hillsdale, NJ, Lawrence Erlbaum, 1987

Miller JP: How Kohut actually worked. Progress in Self Psychology 1:13–30, 1985

Mitchell SA: Relational Concepts in Psychoanalysis: An Integration. Cambridge, MA, Harvard University Press, 1988

Modell AH: "The holding environment" and the therapeutic action of psychoanalysis. J Am Psychoanal Assoc 24:285–307, 1976

Ogrodniczuk JS (ed): Understanding and Treating Pathological Narcissism. Washington, DC, American Psychological Association, 2013

Ornstein PH: A discussion of the paper by Otto F. Kernberg on "Further contributions to the treatment of narcissistic personalities." Int J Psychoanal 55:241–247, 1974a

Ornstein PH: On narcissism: beyond the introduction, highlights of Heinz Kohut's contributions to the psychoanalytic treatment of narcissistic personality disorders. Annual of Psychoanalysis 2:127–149, 1974b

Ornstein P: Psychoanalysis of patients with primary self-disorder: a self psychological perspective, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 147–169

Piper WE, Ogrodniczuk JS: Group treatment for personality disorders, in The American Psychiatric Publishing Textbook of Personality Disorders. Edited by Oldham JG, Skodol A, Bender O. Washington, DC, American Psychiatric Publishing, 2005

Ritter K, Dziobek I, Preibler S, et al: Lack of empathy in patients with narcissistic personality disorder. Psychiatry Res 187:241–247, 2011

Ronningstam E: Psychoanalytic theories on narcissism and narcissistic personality, in The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings, and Treatments. Edited by Campbell WK, Miller JD. Hoboken, NJ, Wiley, 2011, pp 41–55

Ronningstam EF: Treatment of narcissistic personality disorder, in Treatments of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO, Washington, DC, American Psychiatric Publishing, 2014

Ronningstam E, Gunderson J, Lyons M: Changes in pathological narcissism. Am J Psychiatry 152:253–257, 1995

Rose P: The happy and unhappy faces of narcissism. Pers Individ Diff 33:379–391, 2002

Rosenfeld HA: On the psychopathology of narcissism: a clinical approach. Int J Psychoanal 45:332–337, 1964

Roth BE: Narcissistic patients in group psychotherapy: containing affects in the early group, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 221–237

Rothstein A: The Narcissistic Pursuit of Perfection. New York, International Universities Press, 1980

Russ E, Shedler J, Bradley R, et al: Refining the construct of narcissistic personality disorder: diagnostic criteria and subtypes. Am J Psychiatry 165:1473–1481, 2008

Stein J: The new greatest generation. Time, May 20, 2013, pp 26–34

Stein MH: Book review of The Restoration of the Self by Heinz Kohut. J Am Psychoanal Assoc 27:665–680, 1979

Steiner J: Seeing and being seen: narcissistic pride and narcissistic humiliation. Int J Psychoanal 87:939–951, 2006

Stinson FS, Dawson DA, Goldstein RB, et al: Prevalence, correlates, disability, and comorbidity of DSM-IV narcissistic personality disorder: results from the Wave II National Epidemiological Survey on Alcohol and Related Conditions. J Clin Psychiatry 69:1033–1045, 2008

Twenge JM, Campbell WK: The Narcissism Epidemic: Living in the Age of Entitlement. New York, Free Press, 2009

Vernon PA, Villani VC, Vickers LC, et al: A behavioral genetic investigation of the dark triad and the big V. Journal of Personality and Individual Differences 44:445–452, 2008

Wilson M: The analyst's desire and the problem of narcissistic resistances. J Am Psychoanal Assoc 51:72–99, 2003

Wink P: Two faces of narcissism. J Pers Soc Psychol 61:590–597, 1991

Winnicott DW: The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development. London, Hogarth Press, 1965

Wong N: Clinical considerations in group treatment of narcissistic disorders. Int J Group Psychother 29:325–345, 1979

Wong N: Combined group and individual treatment of borderline and narcissistic patients: heterogeneous versus homogeneous groups. Int J Group Psychother 30: 389–404, 1980

Yalom ID: The Theory and Practice of Group Psychotherapy, 3rd Edition. New York, Basic Books, 1985

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CHAPTER 17

CLUSTER B PERSONALITY DISORDERS

Antisocial

Antisocial patients are perhaps the most extensively studied of all those with personality disorders, but they are also the patients whom clinicians tend to avoid the most. In the therapeutic situation, these patients may lie, cheat, steal, threaten, and otherwise act irresponsibly and deceptively. They have been referred to as "psychopaths," "sociopaths," and "character disorders"—terms that, in psychiatry, have traditionally been equated with being untreatable. Some might even argue that such patients should be regarded as "criminals" and should not be included under the purview of psychiatry. Clinical experience suggests, however, that the antisocial label is applied to a broad spectrum of patients, ranging from the totally untreatable to those who are treatable under certain conditions. The existence of this latter group warrants a detailed understanding of these patients so that those amenable to help can receive the best possible treatment.

In his classic work *The Mask of Sanity,* Hervey Cleckley (1941/1976) provided the first comprehensive clinical description of these patients. As his title implies, Cleckley viewed the psychopath as an individual who was not overtly psychotic but whose behavior was so chaotic and so poorly attuned to the demands of reality and society that it indicated a psychosis beneath the surface. Whereas psychopaths seemed to be able to relate superficially to other people, they were completely irresponsible in all their relationships and had no regard for the feelings or concerns of others.

The term *psychopath* fell out of favor during the decades following the appearance of Cleckley's landmark work. *Sociopath* was used for a while, ostensibly as a reflection of the social rather than psychological origins of some of the difficulties faced by these individuals. By the time the American Psychiatric Association's second *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II; American Psychiatric Association 1968) was published in 1968, the term *antisocial personality* had become the preferred nomenclature. With the arrival of DSM-III in 1980 (American Psychiatric Association 1980), the diagnosis of antisocial personality disorder (ASPD) had been considerably altered from Cleckley's original description. Although the DSM-III criteria provided more diagnostic detail than those for any other personality disorder, they narrowed the focus of the disorder to a criminal population likely to be connected with oppressed and disadvantaged lower socioeconomic groups (Halleck 1981; Meloy 1988; Modlin 1983).

When the DSM-III criteria were applied to incarcerated offenders, researchers found that the majority of such populations (50%–80%) had diagnosable ASPD (Hare 1983; Hart and Hare 1998). Strikingly different results were obtained when researchers used diagnostic criteria that more closely resembled the tradition of Cleckley, in which psychopathy was emphasized. For example, if Hare's Psychopathy Checklist—Revised (PCL-R) were used, only about 15%–25% of the incarcerated offender population would qualify as psychopaths (Hare 1991; Hare et al. 1991; Ogloff 2006). In a study of 137 treatment-seeking cocaine-dependent women (Rutherford et al. 1999), more than a quarter of the women had diagnosable ASPD by DSM criteria, but only 1.5% were diagnosed with a moderate level of psychopathy by the PCL-R. This instrument relies on expert clinical ratings rather than self-report and includes items such as irresponsibility; impulsivity; lack of realistic, long-term goals; promiscuous sexual behavior; early behavioral problems; parasitic lifestyle; callousness and lack of empathy; shallow affect; lack of remorse or guilt; need for stimulation and proneness to boredom; grandiose sense of self-worth; and glibness associated with superficial charm.

The term *psychopath* has grown again in popularity in recent years as a diagnostic term that implies particular psychological and biological features that are not captured in the DSM-5 criteria of ASPD (Box 17–1; American Psychiatric Association 2013) (Hart and Hare 1998; Meloy 1988, 1995; Person 1986; Reid et al. 1986).

Psychopathy, as defined by Hare (1991), emphasizes the traits cataloged previously, which fall into interpersonal/psychodynamic features on the one hand, and antisocial acts on the other. Although these two components are obviously correlated, they may occur separately in some individuals (Livesley 2003). Some individuals may be lacking in empathy or be callous, gran-

Box 17–1. DSM-5 Criteria for Antisocial Personality Disorder

301.7 (F60.2)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

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diose, and manipulative, but they may not manifest the behavioral problems on that component of the Hare construct. As a general principle, however, psychopathy is much more severe in both its clinical manifestations and its treatment resistance. These patients probably have substantial neuropsychological differences compared with nonpsychopaths and may be more ruthless and more incapable of any type of emotional attachment except for sadomasochistic interactional style based on power (Meloy 1988). Hare (2006) estimates that 20%–50% of individuals who meet criteria for ASPD also meet criteria for psychopathy.

The DSM-5 criteria are not particularly useful in determining treatability. With antisocial patients, the clinician must determine first and foremost whether a particular patient is treatable under the circumstances. This dilemma can be conceptualized by viewing the antisocial presentation as a subcategory of narcissistic personality disorder (Kernberg 1984, 1998; Meloy 1988, 1995; Reid 1985). Indeed, there is a narcissistic continuum of

antisocial pathology ranging from the most primitive psychopathy in its purest form to narcissistic personality disorder with ego-syntonic antisocial features and to narcissism in which the patient is simply dishonest in the transference (Kernberg 1984, 1998).

Clinicians will encounter many patients with antisocial features. The dynamic psychiatrist should approach each patient with this narcissistic continuum in mind. Using both dynamic understanding and careful diagnosis (discussed later in this chapter) related to psychopathy and narcissistic and antisocial pathology, clinicians can make a dynamically informed decision about whether a patient is treatable and what conditions warrant a treatment effort. In this chapter the term *psychopath* is used narrowly to connote that subgroup of patients captured by the Hare PCL-R criteria and the psychodynamic descriptions of Meloy (1988, 1995) and Person (1986). *Antisocial patients* will be used generically to describe patients along the continuum who show varying degrees of antisocial behavior.

Epidemiology

A considerable body of knowledge has been accumulated regarding the epidemiology of ASPD, which has a 3.6% lifetime prevalence in the U.S. population (Black 2013). Persons with this disorder are more commonly found in impoverished central city areas, and many drop out of high school before graduation. There is a downward drift in the lives of antisocial individuals (Person 1986), who tend to make and lose money cyclically until they "burn out" in middle age, often accompanied by severe alcoholism and debilitation (Halleck 1981). Even though their impulsivity may improve with aging, however, they continue to have struggles with work, parenting, and romantic partners (Paris 2003). Some die prematurely.

There is a striking correlation between antisocial character pathology and substance abuse (Cadoret 1986; Halleck 1981; Meloy 1988; Modlin 1983; Reid 1985; Vaillant 1983; Walsh et al. 2007). It is also well established, of course, that criminal activity is intimately tied to substance abuse (Holden 1986). Among felons, 52%–65% have been found to be drug abusers. Comorbidity of substance abuse with ASPD ranges from 42% to 95% (Meloy and Yakeley 2014).

It is generally assumed that most patients with antisocial problems are male, and indeed the male-to-female ratio for ASPD is about 4:1 (Black 2013). Familial links between psychopathy and somatization disorder (hysteria) have been extensively documented (Cadoret 1978; Cloninger and Guze 1975; Cloninger et al. 1984; Woerner and Guze 1968). One proposed explanation for this correlation is that gender influences whether individu-

als with hysterical or histrionic personality tendencies will develop antisocial personality or somatization disorder (Lilienfeld et al. 1986).

Psychopathy can and does occur in female patients, despite its much more common occurrence among males. Clinicians may overlook the diagnosis in females because of sex role stereotypes. A seductive and manipulative woman who exhibits considerable antisocial activity is much more likely to be labeled hysterical, histrionic, or borderline, especially by male clinicians. One 19-year-old hospitalized female patient had been involved in extensive antisocial behavior, including the murder of a man she had said was attempting to rape her, as well as stealing, lying, and undermining the treatment of other patients. At one point during her hospitalization, she convinced two male patients to take a crowbar to her window to help her escape. After flying across country with the two men (using her parents' credit cards), she abandoned them without money in an airport. She later returned to the hospital, and her treatment reached a turning point when she started a fire in her room that threatened the safety of everyone on her hospital unit. Because this patient was attractive, seductive, and not without interpersonal charm, her treaters kept giving her the benefit of the doubt. Some even viewed her behavior as reflecting "depression" rather than antisocial pathology. Yet she met both the DSM-5 (American Psychiatric Association 2013) criteria for ASPD and the criteria for psychopathy.

The gender differences in the diagnosis of personality disorders have received relatively little attention in personality disorder research. However, an investigation of 665 college students showed a linkage between traditionally defined masculine traits and antisocial tendencies (Klonsky et al. 2002). Some speculation has also arisen that histrionic personality disorder may be a female variant of psychopathy, whereas ASPD is a male variant. Research has not borne out this distinction, and further study is clearly needed (Cale and Lilienfeld 2002).

Psychodynamic Understanding

A comprehensive understanding of ASPD must begin with recognition that biological factors clearly contribute to the etiology and pathogenesis of the disorder. Family studies of antisocial personality disorder suggest that children who have one antisocial parent have approximately a 16% likelihood of developing the disorder (Black 2013). Although twin studies are convincing evidence that genetic factors play a role, environmental abuse and neglect are probably involved as well. In fact, ASPD appears to be a model disorder with which to examine the interaction of genes and environment. Research has consistently shown that a genetic vulnerability acted on by adverse en-

vironmental factors works synergistically to produce antisocial or criminal behavior (Cadoret et al. 1995; Caspi et al. 2002; Foley et al. 2004; Hodgins et al. 2001; Raine et al. 1996, 1997). In the Dunedin Multidisciplinary Health and Development Study (Caspi et al. 2002), the investigators followed a birth cohort of 1,037 children prospectively at ages 3, 5, 7, 9, 11, 13, 15, 18, and 21. Ninety-six percent of the sample was then contacted at age 26 and evaluated. Between the ages of 3 and 11 years, 8% experienced "severe" maltreatment, 28% experienced "probable" maltreatment, and 64% experienced no maltreatment. Maltreatment was defined as maternal rejection, repeated loss of a primary caregiver, harsh discipline, physical abuse, and sexual abuse. The investigators determined that a functional polymorphism in the gene responsible for the neurotransmitter metabolizing enzyme monoamine oxidase–A (MAO-A) was found to moderate the effect of maltreatment. Males with low MAO-A activity genotype who were maltreated in childhood had elevated antisocial scores. Males with high MAO-A activity did not have elevated antisocial scores, even when they had experienced childhood maltreatment. Of males with both low MAO-A activity genotype and severe maltreatment, 85% developed antisocial behavior.

Foley et al. (2004) investigated conduct disorder in 514 male twins ages 8–17 years. Their findings replicated those of the Dunedin study. A Swedish investigation (Nilsson et al. 2006) of a randomized sample of 81 male adolescents provided another replication. The MAO-A genotype appeared to have no effect on adolescent criminal activity if the genotype were considered alone, that is, without the adverse environmental factors. Hence, the three studies together offer strong support for a specific interaction between a genotype and traumatic events early in life. In other words, the genotype may moderate a child's sensitivity to environmental stressors, and the combination of genetic vulnerability and adverse experience appears to produce the appearance of antisocial behavior. It is important to note, however, that an additional study (Young et al. 2006) of 247 male adolescent patients with persistent conduct problems did not support the hypothesis that a polymorphism in the gene encoding MAO-A contributes to the genetic risk for conduct disorder. In this investigation, the level of abuse and maltreatment clearly played a role in the development of conduct disorder, but the researchers were unable to identify an interaction with the genotype found in the other studies.

Another elegant study of the interplay between genes and the environment suggests that the unique environment, *unshared* by siblings in the same family, may have a substantial impact on the development of antisocial behavior. Reiss et al. (1995, 2000) studied 708 families with at least two same-sex adolescent siblings involving multiple variations. Ninety-three families had monozygotic twins, 99 had dizygotic twins, 95 had ordinary siblings,

181 had full siblings in stepfamilies, 110 had half-siblings in stepfamilies, and 130 were characterized by genetically unrelated siblings in stepfamilies. Data on parenting styles were collected by video recordings and by questionnaire. Approximately 60% of the variance in adolescent antisocial behavior could be accounted for by negative and conflictual parental behavior directed specifically at the adolescent.

The investigators suggested that certain heritable characteristics of the children evoked harsh and inconsistent parenting. By contrast, siblings without those heritable characteristics did not evoke negative parental behavior, and these siblings seemed to experience a protective effect when harsh parental behavior was directed at the other sibling. Reiss et al. (2000) found that family response to these heritable characteristics tended to take one of four forms: it could 1) exacerbate troublesome aspects of the child, 2) enhance desirable features of the child, 3) protect the child from the negative outcomes related to difficult behavior, or 4) lead parents to back off from the difficult child in an attempt to protect the sibling with better prospects. They suggested that "the encoding of genetic information into family processes might rival in importance, and serve in tandem with, the much better known process of RNA encoding—the critical intracellular transduction of genetic information on the road to protein synthesis" (p. 386).

The data from this family study were further analyzed with the aim of determining whether latent genetic factors and measured parent-child relationships interacted in predicting adolescent antisocial behavior and depression (Feinberg et al. 2007). This investigation found that an interaction of genotype with both parental negativity and low warmth predicted overall antisocial behavior but not depression. In other words, the genetic influence was greater for adolescent antisocial behavior when parenting lacked warmth and showed greater negativity.

Evidence is also accumulating about characteristics of the biological substrate for psychopathy and ASPD. Levels of 5-hydroxyindoleacetic acid (5-HIAA) are significantly lower in infants with family histories of ASPD than in those without such family histories (Constantino et al. 1997). Psychopathy in particular appears to have strong biological origins, suggested by the study of children with callous-unemotional traits, including such characteristics as lack of empathy and an absence of guilt (Blair et al. 2001). These children have difficulty processing fear and sadness. When boys who have callous-unemotional traits are compared with control subjects of the same age, these boys have much less amygdalar reactivity to fearful faces (Jones et al. 2009). Moreover, poor autonomic peer conditioning is a strong correlate of adult criminal and psychopathic tendencies (Gao et al. 2010). Hence, children who grow up to be psychopaths show no indication of having had the kind of learning that leads to an increase in anxiety and partici-

patory fear when an antisocial act is contemplated. These children, as early as the age of 3, show a lack of fear of consequences for their actions, as measured by reduced electrodermal reactivity. The amygdala processes fear, shame, and guilt and is involved in the development in young children of the desire to behave well. Callous-unemotional children do not feel uncomfortable when they hurt someone or transgress parental rules. In imaging studies, individuals with psychopathy show bilateral volume reductions in the amygdala compared with controls (Yang et al. 2009). There are also striking linkages between lowered autonomic nervous system responsiveness and risk for criminal behavior (Brennan et al. 1997; Raine et al. 1990, 1995). In fact, heightened autonomic nervous system responsiveness appears to be protective against criminal behavior in prospective follow-along studies of teenagers. From a psychodynamic perspective, individuals who possess strongly internalized standards of right and wrong—often associated with the superego and ego ideal—experience anxiety and heightened autonomic responsiveness in the form of guilt when they transgress those moral standards.

Patients with antisocial personality disorder often present with comorbid anxieties and mood disorders. However, one of the striking differences between psychopathy and ASPD is that mood and anxiety disorders are rarely present with psychopathy. It appears that the lack of amygdalar reactivity due to structural deficits in the area prevents psychopathic individuals from developing mood or anxiety disorders (Blair 2012). Psychopaths also have reduced thickness in the temporal cortex and reduced connectivity between the insula and dorsal anterior cingulate cortex (Ly et al. 2012). The capacity to learn fear from experience depends on integrated functioning of the amygdala and temporal cortex, and psychopaths appear to lack that integration (Blair 2012).

A growing body of evidence is documenting anatomical and functional differences characteristic of psychopaths. Twenty-five psychopaths were compared with 18 subjects with borderline personality disorder and 24 control subjects (Herpertz et al. 2001). The psychopaths were characterized by decreased electrodermal responsiveness, the absence of a startle reflex, and less facial expression. The researchers concluded that psychopathic individuals have a pronounced lack of fear in response to events and a general deficit in processing affective information. The emotional hyporesponsiveness was striking and highly specific to psychopaths. In yet another investigation by Raine and colleagues (2003), 15 men with high psychopathy scores were compared with 25 matched control subjects regarding the corpus callosum. Those with psychopathy had a statistically significant increase in callosal white matter volume as well as in callosal length. They also showed a 15% reduction in callosal thickness and an increased functional interhemispheric

connectivity. The investigators suggested that atypical neural development processes involving an arrest of early axonal pruning or increased white matter myelination may be responsible for these corpus callosum abnormalities in psychopathy.

Various neuropsychological deficits in childhood also appear to predict the development of ASPD. For example, children with attention-deficit/hyperactivity disorder are at significantly higher risk for subsequent ASPD (Mannuzza et al. 1998). Men who are exposed prenatally to severe maternal nutritional deficiency during the first and/or second trimesters of pregnancy have shown increased risk for ASPD (Neugebauer et al. 1999). Using structural magnetic resonance imaging, Raine et al. (2000) found that patients with antisocial personality had an 11% reduction in prefrontal gray matter volume compared with healthy subjects, psychiatric control subjects, and 26 subjects with substance dependence. The investigators suggested that this structural deficit may relate to the low autonomic arousal, lack of conscience, and difficult decisions typical of antisocial and psychopathic individuals.

An elegantly designed prospective study (Johnson et al. 1999) demonstrated that childhood neglect and physical abuse (but not sexual abuse) predicted an increased prevalence of adult antisocial symptoms. Although it is true that experiences of childhood abuse may predict symptoms of ASPD in adults, the etiology cannot be reduced to a simple formula that victims become victimizers. In one study (Luntz and Widom 1994), 86% of abused and neglected children did not grow up to have ASPD, whereas 7% without such histories did. Likewise, in an investigation of 85 incarcerated women (Zlotnick 1999), childhood abuse was not associated with ASPD.

The heritable characteristics of the child, often compounded by perinatal brain injury, may create specific difficulties in parenting. The child may be difficult to soothe and may lack the normal affective responsiveness that the parents long to see. In some cases, parents may already have abusive tendencies because of their own psychopathology; in others, they may grow increasingly impatient and irritated with the child who does not respond as they wish. Meloy (1988) noted two separate processes that often take place in the development of antisocial individuals. One is a profound detachment from all relationships and from affective experience in general. The other is a more object-related path characterized by sadistic attempts to bond with others so as to exercise power and destructiveness. There is also a significant problem in internalization of others because of the genetic/biological deficits in the child and the adverse home environment into which the child is born.

The serious impairment of internalization in the psychopath obviously leads to a massive failure of superego development—the classical hallmark, in a dynamic sense, of the psychopath. The absence of any moral sense in

these individuals is one of the chilling qualities that make them seem lacking in basic humanness. Their only value system of any consequence is the exercise of aggressive power, and their only trace of superego development may be the sadistic superego precursors (or stranger selfobjects) manifested by their sadistic and cruel behavior (Kernberg 1984).

Higher-level patients, who do not fit the category of the "pure" psychopath, may exhibit superego lacunae (Johnson 1949). These individuals, because of their relatively more favorable constitutional factors and environmental experiences with parenting, have some semblance of a conscience but with circumscribed areas in which the superego does not seem to operate. Some of these individuals have been subtly or not-so-subtly encouraged in their antisocial behavior by one or both parents.

> Allen was a 10-year-old boy who was admitted to the hospital by his parents. During the admission interview with the psychiatrist and social worker, his mother and father described a long history of aggressive behavior. Allen had repeatedly fought at school, engaged in minor acts of vandalism of neighbors' property, and refused to obey his parents. Allen's father described the incident that finally precipitated his son's admission to the hospital: "This old guy was driving by our house, and Allen was out in the yard with his bow and arrow. Even though the guy was driving 35 miles an hour, Allen was able to shoot an arrow through the car's windshield and hit the guy in the eye. You have to admit that it was a pretty good shot." As a smile flickered across Allen's father's lips, a confused look appeared on Allen's face.

White-collar criminals often fit this category of superego lacunae. Their narcissistic personality structure has allowed them to succeed, but certain defects in their conscience eventually become manifested in antisocial behaviors that are detected by others. It is important in this context to distinguish between antisocial *behavior* and true antisocial personality. Behavior of an antisocial nature may arise from peer pressure, from neurotic conflict, or from psychotic thinking. In these cases, it may bear no relation to ASPD.

Another aspect of superego pathology more characteristic of the true psychopath than of the higher-level narcissistic variants is a complete lack of effort to morally justify or rationalize the antisocial behavior (Meloy 1988). When confronted with their antisocial behavior, psychopaths are likely to respond with self-righteousness, declaring that the victims of their antisocial acts deserved what they got. Psychopaths may also choose to lie and to avoid any responsibility for their behavior.

> Mr. HH was a 23-year-old man who had been involuntarily committed to long-term hospitalization by the court. Shortly after admission, he was seen by a consultant, and the following dialogue took place:

CONSULTANT: What brings you to the hospital?
MR. HH: The court sent me.
CONSULTANT: How come?
MR. HH: I was in a car accident, and my best friend was accidentally killed.
CONSULTANT: How did it happen?
MR. HH: I was driving down the street, minding my own business, when the guy in front of me slams on his brakes. I plow into his rear end, and the gun in my glove compartment goes off and accidentally shoots my friend through the head.
CONSULTANT: Why did you have a gun in your glove compartment?
MR. HH: You gotta have a gun in the neighborhood I come from. I gotta protect myself. There's all kinds of drug dealers around.
CONSULTANT: Why did the court commit you to a hospital as the result of an accident?
MR. HH: Good question.
CONSULTANT: Do you have any emotional problems?
MR. HH: No, I'm a pretty happy-go-lucky guy.
CONSULTANT: Have you had any other problems with the law?
MR. HH: The only other thing that happened wasn't my fault either. These buddies of mine ripped off a dollar-changing machine from a laundromat and left it on my porch as a gag. The police thought I did it and arrested me.

Mr. HH's disavowal of responsibility shows his absence of concern about his "best friend" and his complete inability to acknowledge any of his own problems that might have contributed to his situation. This vignette underscores the difficulty therapists may have engaging antisocial patients in treatment because they externalize all problems.

Antisocial behavior is most usefully characterized as a primitive variant of the narcissistic personality disorder continuum (Kernberg 1984, 1998; Meloy 1988, 1995). Figure 17–1 illustrates this continuum. At the bottom of the continuum are psychopathic individuals who cannot imagine altruism in others and who are totally incapable of investing themselves in nonexploitative relationships. The next step up on the continuum involves antisocial personality disorder proper, in which there is some capacity for anxiety and depression. One step up from antisocial personality disorder is malignant narcissism, characterized by ego-syntonic sadism and a paranoid orientation. Persons in this category differ from psychopathic and antisocial individuals in that they have some capacity for loyalty and concern for others. They also can imagine that people other than themselves may have moral concerns and convictions. The next category in the continuum includes patients with narcissistic personality disorder who show antisocial behavior. These individuals lack the paranoid and sadistic qualities of the

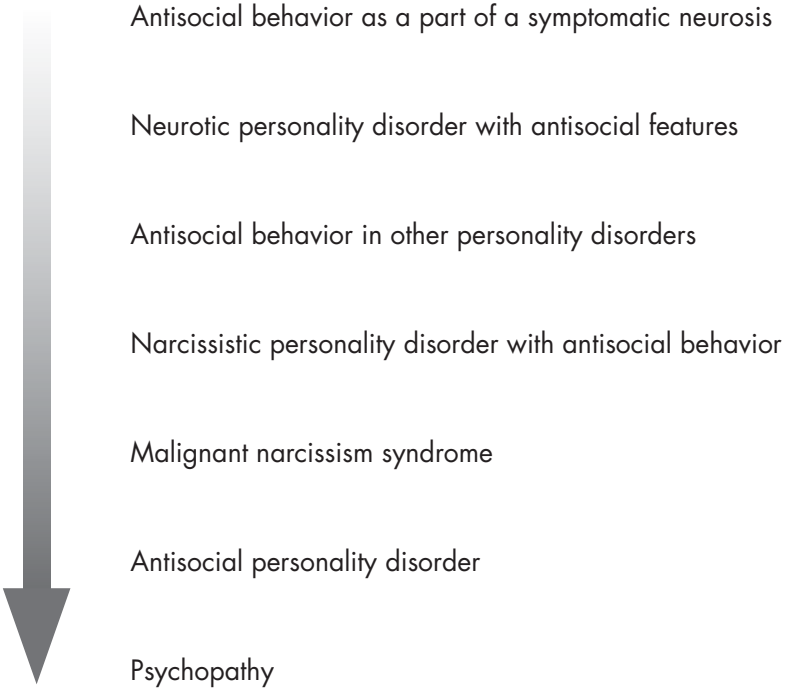
Antisocial behavior as a part of a symptomatic neurosis
Neurotic personality disorder with antisocial features
Antisocial behavior in other personality disorders
Narcissistic personality disorder with antisocial behavior
Malignant narcissism syndrome
Antisocial personality disorder
Psychopathy

FIGURE 17–1. A continuum of antisocial and psychopathic behavior.
Source. Based on Kernberg 1998.

malignant narcissist, but they can be ruthlessly exploitative of others in the service of their own goals. However, they do experience guilt and concern at times, and they also may be capable of realistic planning for the future. Their difficulty in making a commitment to in-depth object relations may be reflected in what appears to be antisocial behavior. As one ascends the hierarchy on the continuum, one encounters occasional antisocial behavior in other personality disorders, such as borderline, histrionic, or paranoid personality disorder. These phenomena occur in individuals with much more developed superego structures. At the top two tiers of the continuum, one finds individuals with neurotic characterological traits who may behave in an antisocial manner out of an unconscious sense of guilt, in the hope of being caught and punished. All variations of the narcissistic and antisocial personality disorders may present in individuals who are charming and manipulative in such a way that others are frequently duped.

In the hierarchy above, I have deliberately left out a controversial category called the *successful psychopath.* One frequently reads of "smooth operators" who function well in business, politics, law, or law enforcement who

have eluded arrest or conviction. Although there are formidable methodological challenges in attempting to study this group that has avoided arrest, some investigators have found ways to study them. A study in the greater Los Angeles area was conducted involving 91 men (Ishikawa et al. 2001). Using the Hare Psychopathy Checklist, the investigators were able to identify 13 successful and 17 unsuccessful psychopaths, the latter of whom had criminal convictions. They also involved 26 controls. In this study, the successful psychopaths did not manifest the reduced autonomic reactivity characteristic of the typical psychopath. In fact, they actually showed significantly greater autonomic reactivity than the control group. When neuropsychological testing was conducted, the successful psychopaths also had much better executive function than either the controls or the unsuccessful psychopaths. The groups did not differ on the measure of skin conductance response; neither did they differ in terms of the rates of self-reported crime. In a subsequent publication by this group (Yang et al. 2005) the investigators reported that unsuccessful psychopaths, but not the "successful" or "white collar" psychopaths, had a 22.3% reduction in frontal gray matter volume compared with control subjects. This finding may be relevant to the poor decision making and unregulated impulsive behavior that allowed the unsuccessful psychopaths to get caught. This combination of normal prefrontal volume and high autonomic functioning may allow successful psychopaths to react sensitively to environmental cues signaling danger and thus avoid conviction. More research is needed, of course, because these individuals rarely come to treatment or criminal prosecution. Hence, the accumulated data are minimal.

The psychodynamically based differentiation of the higher-level, treatable narcissistic patient with antisocial features from the untreatable pure psychopath is a highly complicated undertaking because of the tendency of all antisocial patients to deceive clinicians. There are very few studies to guide the clinician in making this differentiation, but in the following section, I examine some of the criteria that have been found to be useful in determining treatability.

Treatment Approaches

Institutional Treatment

One often hears the sweeping generalization that antisocial and psychopathic patients are untreatable. However, much depends on the context of the treatment and the sophistication of the staff who work in the treatment setting. A review of eight studies using rigorous diagnosis of psychopathy (Salekin et al. 2010) found that three of the eight studies had positive treatment outcomes. When the treatment of psychopathic youths was assessed,

there were promising results in six of eight studies. These treatments took place in correctional or institutional settings where patients could be carefully monitored.

There is a broad consensus that patients with serious antisocial behavior are unlikely to benefit from a treatment approach characterized exclusively by outpatient psychotherapy (Frosch 1983; Gabbard and Coyne 1987; Meloy 1995; Person 1986; Reid 1985). Some form of institutional or residential setting is necessary for even modest improvement. If psychotherapy is employed as a treatment, it must begin while the antisocial patient is contained by the structure of a round-the-clock milieu. These action-oriented individuals will never get in touch with their affective states as long as they have the outlet of behavior to discharge their impulses. It is only when they are immobilized by an inpatient or correctional setting that the treatment staff will begin to see them display emotions such as anxiety and emptiness (Frosch 1983; Person 1986). When these patients have been incorporated into day treatment programs, extensive dropout rates have been recorded (Karterud et al. 2003).

The decision to hospitalize an antisocial patient in a general psychiatry unit containing patients with a variety of diagnoses usually leads to regret. The psychopath's disruptive behavior may grossly interfere with the treatment of other patients and may bring all therapeutic programs in the milieu to a grinding halt. These patients will steal from, sexually exploit, and assault other patients; they will also lie to and ridicule staff members, smuggle drugs and alcohol into the unit, ridicule the treatment philosophy, and corrupt staff members into dishonest and unethical behavior. Some will systematically destroy any therapeutic alliance that other patients have developed with the treatment staff.

> Mr. II was a 46-year-old clergyman forced into hospital treatment by his superiors in the church because his behavior was creating chaos in his congregation. He had seduced a number of women connected with his church and had delighted in "undermining their faith" by challenging the basic tenets of their beliefs. Similar patterns of behavior and object relations occurred in the hospital. Mr. II was silent in most group meetings, but he insidiously "poisoned" the milieu by devaluing staff members in private one-to-one meetings with other patients and by systematically eroding other patients' faith that treatment could be helpful. He viewed all his relationships with female patients and female treaters as sexualized conquests, and even when his sexual acting-out was blocked by the structure of the hospital unit, Mr. II would find other ways to dominate and humiliate women. He often joked with other patients about the relative sexual merits of various female nurses and doctors on the unit, and he devalued the expertise of all staff members regardless of gender. His treatment ended when he planned and executed an elopement with a female inpatient. For several months after Mr. II's depar-

ture, however, his impact on the unit was still felt in the patients' pervasive doubt about the value of treatment—a doubt that he had fueled by his comments and actions.

More sophisticated and intelligent psychopaths may present a different problem in the hospital milieu. Because they are aware that hospitalization is far more comfortable than prison, they may deceive the treatment staff into thinking that they are benefiting greatly from treatment. Such patients may be highly skilled charmers who convince the staff that they should be discharged sooner than initially expected. The behavioral changes of antisocial patients that occur during hospitalization, however, do not usually continue beyond discharge (Frosch 1983). These patients often just go through the motions of treatment without being touched by it. When they revert to their antisocial behavior after discharge, the hospital staff may feel outraged because they have been conned.

To avoid wasting an enormous investment of time, money, and energy, hospital clinicians must determine which antisocial patients warrant a trial of psychiatric hospitalization. There is a broad consensus that true psychopaths do not belong on general psychiatry units because they are unable to benefit from such treatment, perhaps because they tend to transform the experience into an exploitative situation of the proverbial "fox in the chicken coop." Specialized units, such as those in prison settings (Kiger 1967; Sturup 1968), nonmedical community residential programs (Reid and Solomon 1981), and wilderness programs (Reid 1985) may do somewhat better with psychopathic patients and are generally viewed as the only hope for those in this diagnostic category.

In specialized institutional settings in the past, such as the Patuxent Institution in Maryland or the Herstedvester Institution in Denmark, the treatment of the psychopath was enhanced by the homogeneous composition of the milieu. These programs rely heavily on group confrontation by peers. Other psychopaths are familiar with the "con artist" techniques of their cohorts; when these are consistently confronted, their effectiveness is neutralized. These programs also employ a tight structure with clear and rigidly enforced rules. The consequences for rule breaking of any kind are implemented swiftly without any allowance for bargaining or rationalizations on the part of the patients (Reid 1985; Yochelson and Samenow 1977).

Once institutions like these have established control over the lives of the patients and have blocked their usual channels for discharging unpleasant affects through action, these patients may begin to come to terms with their anxiety and aggression. The staff's predictable and consistent responses to all breaks in structure frustrate the usual efforts to get around "the system." These programs depend on court-mandated treatment, however, because the

patients may wish to leave the institution as soon as untoward feelings creep into awareness.

A small subsample of patients with antisocial features, usually those with borderline or narcissistic personality disorders, may benefit from voluntary hospitalization in a general psychiatry unit (Gabbard and Coyne 1987). However, differentiating these patients from the pure psychopath may be difficult because of the intense countertransference reactions evoked by antisocial patients. Mental health professionals, by the very nature of their career choice, are inclined to be charitable and kindly toward those they treat. They are prone to give patients the benefit of the doubt and to see them as somehow treatable no matter how resistant they may appear. This tendency may lead treaters to downplay the extent of ruthlessness in psychopathic patients and to assume that antisocial behavior is really a "cry for help." Hospital staff members in particular often have a deep-seated need to see themselves as capable of treating the untreatable patient. They may take extraordinary steps to connect with a patient who has no interest in meaningful human relationships. In reaching out to such patients, they may collude with the tendency of these patients to minimize the extent of their antisocial behavior and superego pathology. One aspect of this countertransference denial is that clinicians may underdiagnose psychopaths and thus view them as more treatable than they actually are. For example, in one study, only half the patients meeting DSM-III-R (American Psychiatric Association 1987) criteria for ASPD were given that diagnosis (Gabbard and Coyne 1987).

Underdiagnosis may result in viewing the patient as simply narcissistic rather than psychopathic, as immature—with a character structure that is "not yet crystallized," or as primarily a substance abuser. In fact, substance abuse may be an excuse used by psychopaths themselves. In some cases, treatment staff collude with this excuse by arguing vehemently that a patient's crimes occurred only under the influence of drugs and alcohol so the patient should not be viewed as antisocial. These professionals will often argue that treating the patient's substance abuse will eliminate the problematic antisocial behavior. This point of view fails to consider the extensive overlap between psychopathy and drug abuse, as was described earlier in this chapter. Moreover, some studies have demonstrated that a diagnosis of comorbid substance abuse in no way improves a psychopath's prospects for psychological change (Gabbard and Coyne 1987; Woody et al. 1985).

Because of countertransference contamination in distinguishing between the treatable antisocial patient and the pure psychopath, objective criteria are essential to such determinations. "Gut feelings" about particular patients are notoriously unreliable. One study of hospitalized patients with antisocial features identified three predictors of a reasonably positive treatment outcome for these patients in a general psychiatry unit (Gabbard and

Coyne 1987) (Table 17–1): presence of anxiety, depression, and a psychotic diagnosis.

The presence of a diagnosis of a major depressive episode effectively rules out (by definition) the presence of true psychopathy. Patients who meet the criteria for depression have some superego development and some capacity, however minimal, for remorse. Similarly, the presence of anxiety represents some concern about one's behavior and its consequences. De Brito and Hodgins (2009) noted that around half of the antisocial personality disorder population is characterized by co-occurring anxiety and had relatively low levels of callous-unemotional traits as children. One of the reasons anxiety is a good prognostic factor is that it marks a capacity for internalized object relations and may also signal the presence of other affects (Meloy and Yakeley 2014). In addition, anxiety often reflects a capacity to form an emotional bond. Treatment generally depends on some attachment capacity.

Pharmacological treatment has not been particularly effective for the true psychopath. Two recent meta-analyses of trials for pharmacological agents (Khalifa et al. 2010; National Institute for Health and Clinical Excellence 2009) concluded that there is no consistent evidence to support the use of any medication to treat antisocial personality disorder. Finally, the presence of a psychotic diagnosis, such as mania, suggests that pharmacological treatment may improve the prognosis. It is certainly well known that individuals in the midst of a manic episode often exhibit antisocial behavior.

The above study that suggested positive prognostic factors also delineated several predictors of negative treatment response for the same population (see Table 17–1). When there is no other way to keep psychopathic patients involved in treatment, they may benefit from involuntary hospitalization in a specialized penal setting. Psychopaths who are forced to seek hospital treatment as an alternative to prison, however, will simply exploit the opportunity to con the staff of the unit, who are predisposed anyway to see such patients as "sick" or "disturbed" rather than as criminals in need of punishment. Under these conditions, the patients will either disrupt the unit or merely go through the motions of treatment. Many patients will use the hospital to "hide out" from an unresolved legal situation that requires a court appearance. A serious history of violence bodes poorly for treatment, because when these patients become frustrated, they may resort to violence, either against staff members or against other patients. Likewise, a condition involving serious brain impairment may interfere with a patient's ability to understand and benefit from the constructive feedback provided in a hospital milieu, which in turn may increase frustration.

Antisocial patients seldom have all the positive predictors and usually have some of the negative predictors in Table 17–1. Although there is no ideal antisocial patient, each additional positive predictor improves a pa-

TABLE 17–1. Predictors of positive and negative treatment response on a general psychiatric unit

Negative response
History of felony arrest
History of repeated lying, aliases, conning
Unresolved legal situation at admission
History of felony conviction
Hospitalization forced as an alternative to incarceration
History of violence toward others
Diagnosis of organic brain impairment
Positive response
Presence of anxiety
Diagnosis of depression
Psychotic diagnosis other than depression or organic brain syndrome

Note. Based on Gabbard and Coyne 1987.

tient's suitability for hospital treatment, and each negative predictor worsens the patient's amenability to hospital treatment (Gabbard and Coyne 1987).

Even with a relatively favorable profile, antisocial patients present a host of difficulties in a typical psychiatric milieu. Only long-term hospital treatment has a chance of producing any lasting change in these patients. They naturally attempt to continue their pattern of impulsively translating their feelings into actions. The cornerstone of treatment must therefore be a tightly controlled structure. From day one, treaters must anticipate and address likely forms of acting-out in the hospital. Certain expectations must be spelled out at admission. For example, the patient must be told that substance abuse, violence, theft, and sexual relationships with other patients will not be tolerated. If the patient is a drug abuser, all mail must be opened in front of staff members to help prevent the smuggling in of drugs. Patients must be clearly told that they will be accompanied by staff whenever they leave the unit and that they will remain at that level of responsibility for a considerable time. Phone calls and access to cash and credit cards also must be restricted. The patient should be made aware that any breaks in structure will result in clear-cut consequences, such as room restriction. Treatment must be viewed initially as being conducted on a trial basis only—as a period of evaluation—to determine the patient's suitability for treatment. All these conditions may be written out as a "contract" at the time of admission so that the patient will have a copy for reference.

Staff members must scrupulously monitor their countertransference reactions, both as individuals and in the group context. Two common staff reactions are disbelief and collusion (Symington 1980). *Disbelief* may surface as denial that the patient is really "that bad." Rationalizing antisocial behavior as being due to such problems as drug abuse or adolescent rebellion may cause staff members to deny the presence of psychopathic features and to instead view the patient as depressed or misunderstood.

Collusion is one of the most problematic forms of countertransference. A common development in the hospital treatment of antisocial patients is for the patient to corrupt one or more staff members. In the belief that they are helping the patient, the staff members involved in such countertransference acting-out may commit illegal acts or otherwise behave unethically. Staff members have been known to lie on behalf of such patients; they also have falsified records, been seduced into sexual relationships, and helped these patients to escape from the hospital. These countertransference developments can be understood as part of the projective identification process whereby a corrupt aspect of the patient's self enters the treater and transforms that individual's behavior. Staff members who are involved in such countertransference acting-out often report that "I was not acting like myself."

Other common countertransference reactions in the treatment of antisocial patients include feelings of helplessness and impotence in the face of a patient with treatment-resistant illness, wishes to destroy the patient that grow out of anger, and feelings of invalidity and loss of identity (Strasberger 1986). The treatment staff also may fear an assault by these patients, who are often threatening and menacing. (Certain psychopathic patients evoke an intense fear of predation in treaters merely by looking at them [Meloy 1988].) Fear of assault may lead staff members to avoid implementing the firm structure that the patient so desperately needs. To avoid arousing the patient's anger or violence, staff members may rationalize their loose structure and indulgence of the patient. Perhaps one of the most problematic countertransferences is the assumption of psychological complexity in a psychopathic individual (Meloy and Yakeley 2014). Institutional treatment staff often have a great deal of difficulty accepting that the psychopath is fundamentally *different* from them. He has no concern for the feelings or safety of others, and he interacts with treatment staff only in the service of his own interests. The psychopath may exploit this countertransference blind spot by presenting himself as identical to the treaters. This *narcissistic twinship* is a frequent ploy to enlist treaters in a corrupt collusion. By convincing staff members that they and he are fundamentally the same, the patient gains the treaters' trust in ways that allow him greater freedom or power. This attunement to the treatment staff reflects the highly developed sense of empathy

possessed by many psychopathic patients despite the traditional view of these patients as being unempathic.

A major aspect of the hospital treatment of antisocial patients must be the continual focus on their faulty thought processes (Yochelson and Samenow 1976). When they pose as the victim because of being held accountable for their behavior, they must be confronted with how they are responsible for what happens to them. Staff members must also function as auxiliary egos in terms of judgment. The staff must point out over and over how these patients fail to anticipate the consequences of their behavior.

The antisocial patient tends to move directly from impulse to action. The hospital staff must therefore help these patients insert *thought* between impulse and action. In other words, each time an antisocial patient has an impulse, the staff must encourage the patient to think about what may result from the action. In milieu treatment, patients must also learn that impulses and actions grow out of feelings. Often the language of emotions is so foreign to the patients that they cannot identify their internal states. The impulsivity of these patients must also be recognized for the suicide risk it represents. In a Colorado survey of 4,745 subjects, antisocial behavior was linked to suicide risk in both men and women (Verona et al. 2004). The authors noted that suicidal behavior in this cohort was not necessarily related to comorbid depressive disorder.

All these strategies focus on the "here and now" in the milieu, because exploring the childhood origins of such problems is often useless with antisocial patients. Any attempt by the antisocial patient to corrupt staff members must also be confronted *as it occurs*. If an intervention is not made immediately after the acting-out behavior, then the patient may dismiss it or forget it.

Although lack of empathy is generally considered a characteristic of ASPD, this understanding is problematic. Many antisocial individuals have a well-developed capacity to recognize the internal state of another person in the service of exploiting that person. Hence a lack of compassion or emotional resonance might be a better description of this subgroup of antisocial patients.

> Mr. JJ was a 40-year-old man who was admitted to the hospital claiming that he was depressed because his wife and children had died in a car accident. He presented himself as grief-stricken to the female psychiatrist who admitted him, knowing that she would be moved by his deep devotion to the deceased wife. He spoke at length about how their relationship had meant everything to him. At one point he said to the psychiatrist, "We didn't just have sex. We made love." The psychiatrist was deeply touched by his way of characterizing their intimate relationship and was convinced he was telling the truth about his situation. After scamming other patients by selling them pieces of land that did not exist, he disappeared from the hospital. It later

emerged that Mr. JJ had manufactured the death of his family and had used the same story at a number of hospitals in the past so that he could gain admission and implement his scam on unsuspecting patients. His psychiatrist was left feeling duped and humiliated. Although Mr. JJ clearly lacked compassion, he was certainly adept at using his empathy or mentalizing capacity to manipulate others.

Individual Psychotherapy

The pure psychopath, in the dynamic and biological sense, will not respond to psychotherapy, and so it should not be attempted (Kernberg 1984; Meloy 1988, 1995; Woody et al. 1985). Further along the continuum, the patient who has a narcissistic personality disorder with severe antisocial features is somewhat more amenable to psychotherapy. These patients may subtly reveal dependency in the transference, their antisocial behavior may have an enraged quality about it, and their internal "ideal object" may be somewhat less aggressive than that of the pure psychopath (Kernberg 1984; Meloy 1988). They may attempt to rationalize or justify their behavior, thus reflecting some rudimentary value system. Their treatability will be essentially determined by their ability to form some semblance of an emotional attachment to others and to exercise some rudimentary superego functions.

The presence of bona fide depression appears to be a sign of amenability to psychotherapy just as it is a positive predictor of hospital treatment response. In a study of patients with ASPD who were opiate addicts, the presence of depression appeared to indicate suitability for psychotherapy even if there continued to be behavioral manifestations of psychopathy (Woody et al. 1985). The antisocial patients in the study who were not depressed fared poorly in psychotherapy. In addition, the absence of relatedness to others was the most negative predictor of psychotherapy response.

Clinicians who evaluate antisocial patients must feel comfortable making a recommendation for no treatment. Such a decision may be a perfectly rational determination based on the patient's strengths and weaknesses and the danger that the patient might pose to those attempting to treat him. This manner of evaluating treatability differs greatly from the knee-jerk countertransference response described earlier. No body of research demonstrates the efficacy of dynamically informed therapy with this group of patients.

If therapists can accept the fact that these patients will practice deception, they can nevertheless proceed with psychotherapy based on the recommendations of those therapists who have had extensive experience with this population (Adler and Shapiro 1969; Frosch 1983; Kernberg 1984; Lion 1978; Meloy 1988, 1995; Person 1986; Reid 1985; Strasberger 1986; Vaillant 1975). These recommendations can be distilled into nine basic principles of technique:

1. *The therapist must be stable, persistent, and thoroughly incorruptible.* More than with any other patient group, the therapist must be absolutely scrupulous about maintaining normal procedures in therapy (Person 1986). Deviating from the structure and usual context of the hours is inadvisable. These patients will do whatever they can to corrupt the therapist into unethical or dishonest conduct. David Mamet's film *House of Games* (1987) portrayed the perils of attempting to help the antisocial patient by departing from the role of therapist and becoming overinvolved in the patient's life.
2. *The therapist must repeatedly confront the patient's denial and minimization of antisocial behavior.* Pervasive denial even infiltrates the antisocial patient's choice of words. If the patient says, "I ripped off this guy," the therapist needs to clarify, "So, you are a thief." If the patient says, "I offed this dude," the therapist may confront the patient by responding, "So, you are a murderer then." This technique of repeated confrontation enables the therapist to help these patients become aware of their tendency to externalize all responsibility, and they can therefore begin to acknowledge and accept responsibility for their antisocial behavior.
3. *The therapist must help the patient connect actions with internal states.* Just as with antisocial patients undergoing hospital treatment, those in individual psychotherapy require education in this regard.
4. *Confrontations of here-and-now behavior are more effective than interpretations of unconscious material from the past.* In particular, the patient's denigration of the therapist and contemptuous devaluation of the process must be repeatedly challenged.
5. *Countertransference must be rigorously monitored to avoid acting-out by the therapist.* Any collusion must also be carefully avoided, despite the tendency to "take the path of least resistance."
6. *The therapist must avoid having excessive expectations for improvement.* Antisocial patients will detect this *furor therapeuticus* and will take great delight in thwarting their therapist's wishes to change them. Therapists whose self-esteem depends on the improvement of their patients should not treat antisocial patients.
7. *Treatable conditions, such as anxiety and depression, should be identified and treated.*
8. *Mentalization and empathy in the patient should be promoted.* This group of patients has been motivated by self-interest for their entire lives and often do not stop and think about the ultimate impact of what they say and do on others. Hence, trying to develop a capacity of mentalization associated with compassion for the victim may be worth a systematic effort in the psychotherapy. A pilot project of mentalization-based therapy for violent

men with a diagnosis of antisocial personality disorder found that treatment led to a reduction in aggressive acts (McGauley et al. 2011).

9. *The therapist should be alert to legal complications in the treatment.* Few antisocial patients come on their own to outpatient therapy. If they do, one should be wary of their motivation. There may be pending court actions or lawsuits in the near future that have caused them to seek out treatment. They may wish to "look good" in the eyes of a judge or jury by saying that they have emotional problems and are seeking treatment for them.

One final comment is in order. Therapists treating antisocial patients cannot reasonably expect to maintain a neutral position regarding the patient's antisocial activities. Attempting to do so would be tantamount to a silent endorsement of or collusion with the patient's actions. More to the point, the therapist's moral outrage will be evident in myriad nonverbal communications and vocal intonations, so the patient will view any effort at neutrality as hypocritical. When therapists are shocked at a patient's antisocial behavior, they should simply say so (Gedo 1984). Empathy, in accord with the self psychological approach, is both misguided and collusive in such instances.

Even when therapists are capable of navigating the various obstacles of resistance presented by the antisocial patient, their attempts to be effective can still backfire. Competent therapists who are able to avoid being destroyed by the patient are the ones most likely to evoke intense envy, which may surface as hatred toward the loving or idealized object (i.e., the therapist), eventually leading to an intractable negative therapeutic reaction. Despite these pitfalls, however, many experienced clinicians believe that psychotherapeutic efforts with these patients pay off frequently enough to warrant such heroic treatment.

Prospects for Prevention

The research suggesting that the early environment may have a great deal to do with the expression or suppression of particular genes gives the field hope for preventive efforts. Adult individuals with antisocial personality disorder and/or psychopathy present a formidable risk to society and a major challenge to treaters. Perhaps our greatest hope in this area is the preventive efforts of family therapy. Reiss et al. (1995, 2000) emphasized that antisocial behavior is predicted in part by excessively harsh parental responses to heritable characteristics in the children. This observation is one of many that can inform the family therapy approach.

There is at least one report in the literature of a family-based preventive intervention for preschoolers at high risk for antisocial behavior (Brotman et

al. 2007). In this investigation 92 preschool-age siblings of delinquent youths were randomly assigned to one of two groups: a 22-week program of once weekly group sessions for parents and preschoolers accompanied by 10 biweekly home visits conducted during a 6- to 8-month period or a control condition consisting of assessments and monthly telephone calls. Salivary cortisol levels, a measure useful for studying conduct problems and antisocial behavior, were taken at the beginning and end of the protocol. It is well known that low salivary cortisol levels are related to the eventual development of conduct problems, and the researchers hypothesized that early life social experience might alter cortisol release. The social challenge provided by the investigators was entry into an unfamiliar peer group. Relative to controls, the children in the intervention condition had increased cortisol levels in anticipation of the peer social challenge. In other words, they developed the kind of anxiety associated with better prognosis for the development of compassion and concern for others. The investigators concluded that a family-based preventive intervention for children at high risk for antisocial behavior was able to alter stress response in anticipation of a peer social challenge. After the intervention, the children's cortisol levels were close to those found in normally developing low-risk children.

These findings also raise the possibility that early interventions involving individual therapy of parents might serve to influence the expression of genes that lead to antisocial behavior. A neglected benefit of individual psychotherapy is its positive impact on the *offspring* of the patient. In light of the pessimism about the treatment of ASPD, strategies for prevention take on crucial importance from a public health standpoint.

References

Adler G, Shapiro LN: Psychotherapy with prisoners. Curr Psychiatr Ther 9:99–105, 1969

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd Edition. Washington, DC, American Psychiatric Association, 1968

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Black DW: Bad Boys, Bad Men: Confronting Antisocial Personality Disorder (Sociopathy). New York, Oxford University Press, 2013

Blair RJR: Corticol thinning and functional connectivity in psychopathy. Am J Psychiatry 169:684–687, 2012

Blair RJ, Colledge E, Murray L, et al: A selective impairment in the processing of sad and fearful expressions in children with psychopathic tendencies. J Abnorm Child Psychol 29:491–498, 2001

Brennan PA, Raine A, Schulsinger F, et al: Psychophysiological protective factors for male subjects at high risk for criminal behavior. Am J Psychiatry 154:853–855, 1997

Brotman LM, Gouley KK, Huang KY, et al: Effects of a psychosocial family-based preventive intervention on cortisol response to a social challenge in preschoolers at high risk for antisocial behavior. Arch Gen Psychiatry 64:1172–1179, 2007

Cadoret RJ: Psychopathology in the adopted-away offspring of biologic parents with antisocial behavior. Arch Gen Psychiatry 35:176–184, 1978

Cadoret RJ: Epidemiology of antisocial personality, in Unmasking the Psychopath: Antisocial Personality and Related Syndromes. Edited by Reid WH, Dorr D, Walker JI, et al. New York, WW Norton, 1986, pp 28–44

Cadoret RJ, Yates WR, Troughton E, et al: Genetic-environmental interaction in the genesis of aggressivity and conduct disorders. Arch Gen Psychiatry 52:916–924, 1995

Cale EM, Lilienfeld SO: Histrionic personality disorder and antisocial personality disorder: sex-differentiated manifestations of psychopathy? J Pers Disord 16:52–72, 2002

Caspi A, McClay J, Moffitt TE, et al: Role of genotype in the cycle of violence in maltreated children. J Sci 297:851–854, 2002

Cleckley HM: The Mask of Sanity: An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality, 5th Edition. St Louis, MO, CV Mosby, 1941/1976

Cloninger CR, Guze SB: Hysteria and parental psychiatric illness. Psychol Med 5:27–31, 1975

Cloninger CR, Sigvardsson S, von Knorring A-L, et al: An adoption study of somatoform disorders, II: identification of two discrete somatoform disorders. Arch Gen Psychiatry 41:863–871, 1984

Constantino JN, Morris JA, Murphy DL: CSF 5-HIAA and family history of antisocial personality disorder in newborns. Am J Psychiatry 154:1771–1773, 1997

De Brito SA, Hodges S: Antisocial personality disorder, in Personality, Personality Disorder and Violence. Edited by McMurran M. Chichester, UK, Wiley, 2009, pp 144–153

Feinberg ME, Button TM, Neiderhiser JM, et al: Parenting and adolescent antisocial behavior and depression: evidence of genotype X parenting environment interaction. Arch Gen Psychiatry 64:457–465, 2007

Foley DL, Eaves LJ, Wormley B, et al: Childhood adversity, monoamine oxidase A genotype, and risk for conduct disorder. Arch Gen Psychiatry 61:738–744, 2004

Frosch JP: The treatment of antisocial and borderline personality disorders. Hosp Community Psychiatry 34:243–248, 1983

Gabbard GO, Coyne L: Predictors of response of antisocial patients to hospital treatment. Hosp Community Psychiatry 38:1181–1185, 1987

Gao Y, Raine A, Venables PH, et al: Association of poor childhood fear conditioning and adult crime. Am J Psychiatry 167:56–60, 2010

Gedo JE: Psychoanalysis and Its Discontents. New York, Guilford, 1984

Halleck SL: Sociopathy: ethical aspects of diagnosis and treatment. Curr Psychiatr Ther 20:167–176, 1981

Hare RD: Diagnosis of antisocial personality disorder in two prison populations. Am J Psychiatry 140:887–890, 1983

Hare RD: The Hare Psychopathy Checklist—Revised. Toronto, Ontario, Multi-Health Systems, 1991

Hare RD: Psychopathy: a clinical and forensic overview. Psychiatr Clin North Am 29:709–724, 2006

Hare RD, Hart SD, Harpur TJ: Psychopathy and the DSM-IV criteria for antisocial personality disorder. J Abnorm Psychol 100:391–398, 1991

Hart SD, Hare RD: Association between psychopathy and narcissism: theoretical views and empirical evidence, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 415–436

Herpertz SC, Werth U, Lukas G, et al: Emotion in criminal offenders with psychopathy and borderline personality disorder. Arch Gen Psychiatry 58:737–745, 2001

Hodgins S, Kratzer L, McNeil TF: Obstetric complications, parenting, and risk of criminal behavior. Arch Gen Psychiatry 58:746–752, 2001

Holden C: Growing focus on criminal careers. Science 233:1377–1378, 1986

Ishikawa SS, Raine A, Lencz T, et al: Autonomic stress reactivity and executive function in successful and unsuccessful criminal psychopaths from the community. J Abnorm Psychol 110:423–432, 2001

Johnson AM: Sanctions for superego lacunae of adolescents, in Searchlights on Delinquency: New Psychoanalytic Studies. Edited by Eissler KR. New York, International Universities Press, 1949, pp 225–245

Johnson JG, Cohen PA, Brown J, et al: Childhood maltreatment increases risk for personality disorders during early childhood. Arch Gen Psychiatry 56:600–606, 1999

Jones AP, Laurens KR, Herba CM, et al: Amygdala hypoactivity to fearful faces in boys with conduct problems and callous-unemotional traits. Am J Psychiatry 166:95–102, 2009

Karterud S, Pedersen G, Bjordal E, et al: Day treatment of patients with personality disorders: experiences from a Norwegian treatment research network. J Pers Disord 17:243–262, 2003

Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984

Kernberg OF: Pathological narcissism and narcissistic personality disorder: theoretical background and diagnostic classification, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC, American Psychiatric Press, 1998, pp 29–51

Khalifa N, Duggan C, Stoffers J, et al: Pharmacological interventions for antisocial personality disorder. Cochrane Database of Systematic Reviews 2010, Issue 8. Art. No.: CD007667. DOI: 10.1002/14651858.CD007667.pub2

Kiger RS: Treating the psychopathic patient in a therapeutic community. Hosp Community Psychiatry 18:191–196, 1967

Klonsky ED, Jane JS, Turkheimer E, et al: Gender role in personality disorders. J Pers Disord 16:464–476, 2002

Lilienfeld SO, VanValkenburg C, Larntz K, et al: The relationship of histrionic personality disorder to antisocial personality and somatization disorders. Am J Psychiatry 143:718–722, 1986

Lion JR: Outpatient treatment of psychopaths, in The Psychopath: A Comprehensive Study of Antisocial Disorders and Behaviors. Edited by Reid WH. New York, Brunner/Mazel, 1978, pp 286–300

Livesley WJ: Practical Management of Personality Disorder. New York, Guilford, 2003

Luntz BK, Widom CS: Antisocial personality disorder in abused and neglected children grown up. Am J Psychiatry 151:670–674, 1994

Ly M, Motzkin JC, Philippi CL, et al: Corticol thinning in psychopathy. Am J Psychiatry 169:743–749, 2012

Mannuzza S, Klein RG, Bessler A, et al: Adult psychiatric status of hyperactive boys grown up. Am J Psychiatry 155:493–498, 1998

McGauley G, Yakeley J, Williams A, et al: Attachment, mentalization and antisocial personality disorder: the possible contribution of mentalization based treatment. Eur J Psychother Couns 13:1–22, 2011

Meloy JR: The Psychopathic Mind: Origins, Dynamics, and Treatment. Northvale, NJ, Jason Aronson, 1988

Meloy JR: Antisocial personality disorder, in Treatments of Psychiatric Disorders, Vol 2, 2nd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1995, pp 2273–2290

Meloy JR, Yakeley J: Antisocial personality disorder, in Gabbard's Treatment of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO, Washington DC, American Psychiatric Publishing, 2014

Modlin HC: The antisocial personality. Bull Menninger Clin 47:129–144, 1983

National Institute for Health and Clinical Excellence: Antisocial Personality Disorder: Treatment, Management and Prevention. NICE Clinical Guidelines 77. London, National Institute for Health and Clinical Excellence, 2009

Neugebauer R, Hoek H, Susser E: Prenatal exposure to wartime famine and development of antisocial personality disorder in early adulthood. JAMA 282:455–462, 1999

Nilsson KW, Sjoberg RL, Damberg M, et al: Role of monoamine oxidase-A genotype and psychosocial factors in male adolescent criminal activity. Biol Psychiatry 59:121–127, 2006

Ogloff JRP: Psychopathy/antisocial personality disorder conundrum. Aust N Z J Psychiatry 40:519–528, 2006

Paris J: Personality disorders over time: precursors, course and outcome. J Pers Disord 17:479–488, 2003

Person ES: Manipulativeness in entrepreneurs and psychopaths, in Unmasking the Psychopath: Antisocial Personality and Related Syndromes. Edited by Reid WH, Dorr D, Walker JI, et al. New York, WW Norton, 1986, pp 256–273

Raine A, Venables PH, Williams M: Relationships between central and autonomic measures of arousal at age 15 years and criminality at age 24 years. Arch Gen Psychiatry 47:1003–1007, 1990

Raine A, Venables PH, Williams M: High autonomic arousal and electrodermal orienting at age 15 years as protective factors against criminal behavior at age 29 years. Am J Psychiatry 152:1595–1600, 1995

Raine A, Brennan P, Mednick B, et al: High rates of violence, crime, academic problems, and behavioral problems in males with both early neuromotor deficits and unstable family environments. Arch Gen Psychiatry 53:544–549, 1996

Raine A, Brennan P, Mednick SA: Interaction between birth complications and early maternal rejection in predisposing individuals to adult violence: specificity to serious, early onset violence. Am J Psychiatry 154:1265–1271, 1997

Raine A, Lencz T, Bihrle S, et al: Reduced prefrontal gray matter volume and reduced autonomic activity in antisocial personality disorder. Arch Gen Psychiatry 57: 119–127, 2000

Raine A, Lencz T, Taylor K, et al: Corpus callosum abnormalities in psychopathic antisocial individuals. Arch Gen Psychiatry 60:1134–1142, 2003

Reid WH: The antisocial personality: a review. Hosp Community Psychiatry 36:831–837, 1985

Reid WH, Solomon G: Community-based offender programs, in Treatment of Antisocial Syndromes. Edited by Reid WH. New York, Van Nostrand Reinhold, 1981, pp 76–94

Reid WH, Dorr D, Walker JI, et al (eds): Unmasking the Psychopath: Antisocial Personality and Related Syndromes. New York, WW Norton, 1986

Reiss D, Hetherington EM, Plomin R, et al: Genetic questions for environmental studies: differential parenting and psychopathology in adolescence. Arch Gen Psychiatry 52:925–936, 1995

Reiss D, Neiderhiser JM, Hetherington EM, et al: The Relationship Code: Deciphering Genetic and Social Influences on Adolescent Development. Cambridge, MA, Harvard University Press, 2000

Rutherford MJ, Cacciola JS, Alterman AI: Antisocial personality disorder and psychopathy in cocaine-dependent women. Am J Psychiatry 156:849–856, 1999

Salekin RT, Worley C, Grimes RD: Treatment of psychopathy: a review and brief introduction to the mental model approach for psychopathy. Behav Sci Law 28:235–266, 2010

Strasberger LH: The treatment of antisocial syndromes: the therapist's feelings, in Unmasking the Psychopath: Antisocial Personality and Related Syndromes. Edited by Reid WH, Dorr D, Walker JI, et al. New York, WW Norton, 1986, pp 191–207

Sturup GK: Treating the Untreatable: Chronic Criminals at Herstedvester. Baltimore, MD, Johns Hopkins University Press, 1968

Symington N: The response aroused by the psychopath. International Review of Psychoanalysis 7:291–298, 1980

Vaillant GE: Sociopathy as a human process: a viewpoint. Arch Gen Psychiatry 32: 178–183, 1975

Vaillant GE: Natural history of male alcoholism, V: is alcoholism the cart or the horse to sociopathy? Br J Addict 78:317–326, 1983

Verona E, Sachs-Ericsson, N, Joiner TE: Suicide attempts associated with externalizing psychopathology in an epidemiological sample. Am J Psychiatry 161:444–451, 2004

Walsh Z, Allen LC, Cosson DS: Beyond social deviance: substance use disorders and the dimensions of psychopathy. J Pers Disord 21:273–288, 2007

Woerner PI, Guze SB: A family and marital study of hysteria. Br J Psychiatry 114:161–168, 1968

Woody GE, McLellan AT, Luborsky L, et al: Sociopathy and psychotherapy outcome. Arch Gen Psychiatry 42:1081–1086, 1985

Yang Y, Raine A, Lencz T, et al: Volume reduction in prefrontal gray matter in unsuccessful criminal psychopaths. Biol Psychiatry 57:1103–1108, 2005

Yang Y, Raine A, Narr K, et al: Localization of deformations within the amygdala in individuals with psychopathy. Arch Gen Psychiatry 66:986–994, 2009

Yochelson S, Samenow SE: The Criminal Personality, Vol 1: A Profile for Change. New York, Jason Aronson, 1976

Yochelson S, Samenow SE: The Criminal Personality, Vol 2: The Treatment Process. New York, Jason Aronson, 1977

Young SE, Smolen A, Hewitt JK: Interaction between MAO-A genotype and maltreatment in the risk for conduct disorder: failure to confirm in adolescent patients. Am J Psychiatry 163:1019–1025, 2006

Zlotnick C: Antisocial personality disorder, affect dysregulation and childhood abuse among incarcerated women. J Pers Disord 13:90–95, 1999

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CHAPTER 18

HYSTERICAL AND HISTRIONIC PERSONALITY DISORDERS

The DSM-5 (American Psychiatric Association 2013) criteria for histrionic personality disorder (Box 18–1) do not capture the well-integrated and higher-functioning hysterical personality. This latter condition has a time-honored tradition among dynamic clinicians. Unfortunately, the criteria for histrionic personality disorder are so close to the clinical picture presented by narcissistic and borderline patients that they do not lend themselves readily to the traditional hysterical patient. Because both the high-level hysterical personality disorder and the more primitive histrionic personality disorder are commonly encountered in clinical practice, both are considered in this chapter in an effort to make clinically useful distinctions and to inform treatment.

Hysterical Versus Histrionic

The staunchly atheoretical nature of the personality disorder criteria in DSM-5 is particularly problematic when considering patients with hysterical or histrionic tendencies. To determine the appropriate treatment for this diverse group of patients, a careful psychodynamic assessment is far more crucial than a descriptive cataloging of overt behaviors. One primary source of confusion in the related literature has been a tendency to rely on behavioral characteristics instead of dynamic understanding.

Box 18–1. DSM-5 Criteria for Histrionic Personality Disorder

301.50 (F60.4)

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

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A further complication is that the term *hysterical* has been used not only to describe a personality disorder but also to refer to a disease largely of women, characterized by frequent surgeries and multiple somatic complaints, and to denote various conversion symptoms, such as paralysis or blindness, that have no physical basis. The former condition, known as Briquet's hysteria or Briquet's syndrome, is currently subsumed under the somatic symptoms and related disorders in DSM-5 (American Psychiatric Association 2013). Conversion symptoms are classified in that group of conditions as well. Hysterical conversion symptomatology is what opened the gates of the unconscious to Freud and led to the development of psychoanalysis. Freud understood conversion symptoms as symbolic physical symptoms that represented displaced and repressed instinctual wishes. However, there is a broad consensus in modern psychiatry that hysterical conversion symptoms and hysterical personality disorder are not related either clinically or dynamically (Chodoff 1974; Gabbard 2014). Although conversion symptoms can occur in the context of hysterical personality disorder, they also can occur across a wide variety of other character diagnoses.

During the first half of the century, the intrapsychic conflicts associated with the hysterical personality were thought to derive from genital-oedipal

developmental issues. Part of the legacy of Freud's work with hysterical conversion symptoms was the more generalized view that repressed sexuality was of paramount importance in both character neuroses and neurotic symptoms. Clinically unsuccessful psychoanalytic efforts to treat these patients led some to question Freud's formulation. Beginning with Marmor's classic 1953 article, the psychiatric literature has strongly identified pregenital issues as central to the pathogenesis of hysterical personality disorder (Chodoff 1974).

The literature of the past four decades has seen a convergence of opinion regarding the existence of both "healthy" and "sick" hysterical patients (Baumbacher and Amini 1980–1981; Blacker and Tupin 1977; Chodoff 1974; Easser and Lesser 1965; Horowitz 1997, 2001; Kernberg 1975; Lazare 1971; Sugarman 1979; Wallerstein 1980–1981; Zetzel 1968). "Healthy" hysterical patients are referred to by a variety of names, including "good," "phallic," and "true." Even more labels have been applied to those in the latter group—"oral hysterics," "so-called good hysterics," "hysteroids," and "infantile personalities." Some (Gabbard 2014) have argued that there is considerable overlap with borderline personality disorder in this latter group. Indeed, Blagov and Westen (2008) asked a group of 1,201 experienced clinicians to describe a random patient with personality pathology using rigorous psychometrics, including the revised Shedler-Westen Assessment Procedure (SWAP-II), a Q-sort that captures personality and its pathology in adults. Using DSM-IV-TR-based measures (American Psychiatric Association 2000), they identified patients who met histrionic personality disorder (HPD) criteria and found that the most descriptive and most distinctive features of the patients included some features of HPD but also many features of borderline personality disorder. A study of 2,289 day hospital patients in Norway (Bakkevig and Karterud 2010) found a very low prevalence of HPD (0.4%). Most striking was the high comorbidity, particularly with borderline, narcissistic, and dependent personality disorders. The authors concluded that the HPD category has poor construct validity. For reasons of clarity, in this chapter I refer to the healthier group as those with hysterical personality disorder and the more disturbed group as those with histrionic personality disorder.

Defining the exact interrelationship between the hysterical and the histrionic personality is a controversial process. Although some have argued that the two are simply gradations along a continuum (Blacker and Tupin 1977; Lazare 1971; Wallerstein 1980–1981; Zetzel 1968), others have viewed the two groups as so different as to constitute sharply distinct entities (Baumbacher and Amini 1980–1981; Sugarman 1979). Horowitz (1997, 2001) noted that patients who exhibit an interpersonal style characteristic of a histrionic personality disorder may be psychiatrically healthy, neurotic, narcissistic, or borderline in terms of the coherence of their identity and the

continuity of their regard for significant others. These levels are differentiated by the level of integration of self and others in the person schemas of the individual. Person schemas of "all good" and "all bad" that are split off from each other are associated with the borderline level. The histrionic patient organized at a narcissistically vulnerable level has a more cohesive self-schema but is vulnerable to feeling grandiose or extremely impoverished. These individuals also view others as extensions of themselves. The neurotically organized histrionic patient in Horowitz's model has long-standing unresolved internal conflicts that are enacted in repetitive maladaptive relationship cycles in the sphere of intimacy and work. For purposes of this discussion, the neurotically organized histrionic patient is considered identical to the patient with hysterical personality disorder, whereas patients with personalities that are organized at a narcissistic or borderline level are subsumed under the group referred to as having histrionic personality disorder.

What appears to link hysterical persons and histrionic persons is an overlap in overt behavioral characteristics, such as labile and shallow emotionality, attention seeking, disturbed sexual functioning, dependency and helplessness, and self-dramatization. These qualities have come to be associated with the use of "hysterical" by laypersons to mean dramatic overreaction. The paradox is that these characteristics are far more typical of histrionic patients than of hysterical patients. As Wallerstein (1980–1981) noted: "Those who behaviorally look more hysterical in the sense of the dramatic or flamboyant hysterical character type are the very ones who look less hysterical in the sense of the dynamics of the 'good' or 'true' hysteric" (p. 540). Zetzel (1968) similarly observed that the "so-called good hysterics" who appear floridly hysterical are often mistaken for analyzable, high-level hysterical patients although they are actually primitively organized and difficult to analyze—patients I refer to here as having histrionic personalities.

Despite the controversy surrounding the validity of the diagnosis, there is little doubt that the individuals who receive this diagnosis live with a good deal of suffering and emotional pain. Skilled clinicians continue to find the diagnosis useful in identifying a cluster of features that provides a conceptual framework that is useful for psychotherapists. Moreover, some research suggests that the characteristics found in these patients are particularly fixed and may not decline with maturity. Although many personality disorders show declines in symptomatology over time, one study of 1,477 patients (Gutierrez et al. 2012) showed that patients with histrionic personality disorder do not show linear reductions in the clinical features over the course of life. Moreover, they may resort to substance abuse to deal with their distress. In an epidemiological study of more than 40,000 individuals (Trull et al. 2010), histrionic personality disorders had the highest rates of comorbidity with lifetime drug dependence (29.72%) of all personality disorders. Per-

sons with HPD clearly are in need of treatment, and clinicians must carefully assess the level of personality functioning so that therapy can be tailored to the individual patient.

Overt interpersonal characteristics may not be extremely useful in understanding the underlying psychodynamic organization of these patients. Horowitz (1997, 2001), for example, has noted that patients who exhibit an interpersonal style characteristic of a histrionic personality disorder may be psychiatrically healthy, neurotic, narcissistic, or borderline in terms of the coherence of their identity and the continuity of their regard for significant others. Overt behavior characteristics, such as attention seeking, self-dramatization, disturbed sexual functioning, dependency, helplessness, and labile and shallow affect, link patients at the higher and lower levels of the spectrum on the surface. The psychotherapist must make fine distinctions between these two subgroups to plan strategic interventions. The neurotically organized individual can be treated with psychoanalysis or a highly exploratory psychotherapy, whereas those with more primitive intrapsychic organizations may require much more of a supportive-expressive approach.

The literature distinguishing the two groups is summarized in Table 18–1, which lists the characteristics that differentiate the neurotically organized (hysterical) personality disorder from the more primitive variant (histrionic) personality disorder (Easser and Lesser 1965; Kernberg 1975; Lazare 1971; Sugarman 1979; Zetzel 1968). The true histrionic personality is more florid than the hysterical in virtually every way. All of the DSM-5 criteria symptoms are more exaggerated in the histrionic person. Greater lability of affect, more impulsivity, and a more overt seductiveness are all hallmarks. The sexuality of these patients is often so direct and unmodulated that it may actually "turn off" members of the opposite sex. Their demanding, exhibitionistic need to be the center of attention may also fail to engage others because of its ruthless nature. In this regard, these patients clearly have much in common with persons who have narcissistic personality disorder.

By contrast, persons who have true hysterical personality disorder may be much more subtly dramatic and exhibitionistic, and their sexuality may be expressed more coyly and engagingly. In addition, Wallerstein (1980–1981) suggested that a sizable group of high-level hysteric patients are not dramatic or flamboyant at all. He described these patients as "constricted wallflowers, shy and even tongue-tied in interpersonal encounter, at extremes mousy and totally inhibited in demeanor and interaction" (p. 540). He persuasively pointed out that a focus on overt behavior rather than underlying dynamics can result in a misdiagnosis.

Patients with hysterical personality disorder are often reasonably successful at work and demonstrate ambition as well as constructive competitiveness. This active mastery can be juxtaposed with the aimless, helpless,

TABLE 18–1. Differentiation of neurotic and primitive variants of histrionic personality disorder

Neurotic (hysterical) variant	Primitive (histrionic) variant
Restrained and circumscribed emotionality	Florid and generalized emotionality
Sexualized exhibitionism and need to be loved	Greedy exhibitionism with a demanding, oral quality that is "cold" and less engaging
Good impulse control	Generalized impulsivity
Subtly appealing seductiveness	Crude, inappropriate, and distancing seductiveness
Ambition and competitiveness	Aimlessness and helplessness
Mature, triangular object relations	Primitive, dyadic object relations characterized by clinging, masochism, and paranoia
Separations from love objects can be tolerated	Overwhelming separation anxiety occurs when abandoned by love objects
Strict superego and some obsessional defenses	Lax superego and a predominance of primitive defenses, such as splitting and idealization when under stress
Sexualized transference wishes develop gradually and are viewed as unrealistic	Intense sexualized transference wishes develop rapidly and are viewed as realistic

dependent quality that keeps histrionic patients from succeeding except in the sense of passively manipulating others to meet their needs. Whereas the true hysterical patient has attained mature whole-object relations characterized by triangular oedipal themes and has been able to form significant relationships with both parents, the histrionic patient is fixated at a more primitive dyadic level of object relations often characterized by clinging, masochism, and paranoia.

Hysterical patients can tolerate separation from their love objects even though they may identify those relationships as their main area of difficulty. Histrionic patients, on the other hand, are often overwhelmed with separation anxiety when apart from their love objects. The strict superego and other obsessional defenses of the hysterical patient contrast with the histrionic patient's typically lax superego and predominantly more primitive defenses, such as splitting and idealization.

When hysterical patients enter psychotherapy or psychoanalysis, sexualized transference wishes develop gradually over a considerable time and

are generally viewed as unrealistic by the patients themselves. Histrionic patients, on the other hand, develop intense erotic transference wishes almost immediately and often view these wishes as realistic expectations. When the wishes are frustrated, the patient may become furious with the therapist for not being more gratifying. Zetzel (1968) pointed out that the hysterical patient's capacity to differentiate the therapeutic alliance from transference feelings is intimately linked with the ability to separate internal from external reality, an ego function that is compromised in the histrionic patient.

The distinguishing features of histrionic personality disorder highlight its close relationship with borderline personality disorder. Kernberg (1975), for example, explicitly conceptualized the infantile personality as having an underlying borderline personality organization. It is not so much genital sexuality as passive and primitive orality that these patients defend against (Lazare 1971).

Patients with hysterical personality disorder, on the other hand, usually present with problems that revolve either around genital sexuality per se or around difficulties with the sexual objects in their lives. Although the hysterical woman has classically been described as "frigid" or anorgasmic, she may also be promiscuous or fully orgasmic but basically dissatisfied with her sexual relationships. She may be unable to make a romantic or sexual commitment to a man who is appropriate for her, instead falling hopelessly in love with an unavailable man. Another recurrent problem for the female hysterical patient is that men often misinterpret her actions as sexual advances, and she is continually surprised at this misunderstanding—a fact that reflects the unconscious nature of her seductiveness.

Gender and Diagnosis

Throughout the history of psychiatry, the hysterical personality has been associated with the female gender. This tendency to think of the diagnosis only in relation to women probably relates more to cultural sex role stereotypes than to psychodynamics. Hollender (1971) and Lerner (1974) have noted that hysterical personality characteristics reflect cultural expectations of how women are supposed to adapt in American society. Another glaring contributor to the overwhelming tendency to view hysterical personality as a disease of women is the fact that, with few exceptions, the literature on the disorder has been written entirely by men (Chodoff and Lyons 1958; Luisada et al. 1974).

Despite the predominant association between hysterical personality and femininity, hysterical personality disorder has been extensively documented in males (Blacker and Tupin 1977; Bollas 2000; Cleghorn 1969; Halleck 1967;

Kolb 1968; Lubbe 2003; Luisada et al. 1974; MacKinnon et al. 2006; Malmquist 1971). The descriptions of male hysterical patients fall into two broad subtypes: the hypermasculine and the passive/effeminate. Those in the hypermasculine subtype are directly analogous to the classical female hysteric in that they are caricatures of masculinity. As noted in Chapter 16, a study of 655 college students (Klonsky et al. 2002) found that both narcissistic and histrionic features were associated with men and women who typically behaved consistent with their gender. They may be "Don Juans" who act seductively toward all women and may even engage in antisocial behavior. The subtype of passive/effeminate males may be "foppish" (MacKinnon et al. 2006), flamboyant homosexuals or passive, impotent heterosexuals who are fearful of women. The same distinction between the high-level hysterical personality and the lower-level histrionic personality can be made in male patients, based largely on the same criteria used to distinguish the two groups in females.

In a study of 27 male patients with hysterical personality disorder, Luisada et al. (1974) found that the vast majority were heterosexual but that all had some form of disturbed sexual relationships. Antisocial behavior, such as lying and unreliability, were common problems in the group, as were alcohol and drug abuse. These investigators identified both passive/effeminate and hypermasculine subtypes, with unstable relationships typical of both. Many of these patients would probably receive a diagnosis of narcissistic personality disorder, some with antisocial features, but as a group they tended to have much more warmth toward and empathy for others than the true narcissist. Although some researchers have attempted to link psychopathy and histrionic personality disorder (Hamburger et al. 1996), the literature provides rather weak support for the notion that histrionic personality disorder is a female-typed variant of psychopathy or antisocial personality disorder (Cale and Lilienfeld 2002). Mitchell (2000) argued that by feminizing the symptoms of hysteria over time, male hysterical patients became marginalized in psychoanalytic theory and practice. Nevertheless, many of the same themes appear in both genders who have hysterical or histrionic personality disorders. These include seductiveness, promiscuity, sexual jealousy, longings for ideal love, capriciousness, and sexualization.

Cognitive Style and Defense Mechanisms

One aspect of intrapsychic functioning that links the hysterical and the histrionic personality disorders is *cognitive style*. Shapiro (1965) identified the cognitive style typical of patients with these personality disorders as generally "global, relatively diffuse, and lacking in sharpness, particularly in sharp detail. In a word, it is impressionistic" (p. 111). When a therapist asks a pa-

tient with this cognitive style, "How was your weekend?" the response is likely to be along the lines of "just great" or "really awful," without any supportive detail. The same order of response is likely to apply to significant figures in the patient's life. When one hysterical patient was asked to describe her father, she responded, "He's just super!"

Similarly, when patients with this form of cognitive style approach a task, such as psychological testing, they are inclined to avoid concentrating on facts and to instead respond with a hunch. When a highly successful and intelligent professional man was asked to estimate the population of the United States, he hastily replied, "I don't know. I think it's around 5 billion." When the psychologist pressed him for a little more thought about the question, the man recognized that he had given the population of the world rather than the population of the country. The patient was not ignorant, but his hysterical cognitive style made him resent having to concentrate on such details. The therapist may encounter considerable frustration, for example, in getting historical facts about a patient's family background.

This global, impressionistic cognitive style is intimately connected with the use of defense mechanisms by hysterical and histrionic patients (Horowitz 1977a, 1997, 2001). These patients inhibit information processing to blunt strong emotions. Repression, denial, dissociation, and suppression are defensive strategies that also reduce emotional arousal. These patients may say "I don't know" when what they really mean is "I must not know" (Horowitz 1997). In the early literature on hysteria, this blunting of emotional connection was often described as *la belle indifférence,* referring to the female patient's apparent lack of concern about her conversion symptoms. The hysterical or histrionic cognitive style may account for this failure to integrate or recognize implications, consequences, and details of experience.

On the other hand, this inhibition of emotional arousal generally oscillates with exaggerated emotional displays designed to elicit responses from others. Hysterical/histrionic patients deploy their attention globally and diffusely, but much of their focus is on whether others are paying attention to them.

Dissociative states, like conversion symptoms, have often been classified as hysterical phenomena, even though they are found in patients with a variety of diagnoses. The most extreme manifestation of dissociation is dissociative identity disorder, which involves both splitting—in the sense that different self representations are maintained as separate—and repression—in the sense that the primary personality usually has no memory of the alters. The reactions of histrionic patients to their emotional outbursts resemble dissociation and dissociative identity disorder, albeit in attenuated form. These patients often have poor recall of their actions, which they say seemed to be like those of "someone else."

One histrionic patient who also had dissociative symptoms discovered cuts on her left breast but could not explain how they got there. Shortly after this discovery, her husband found her in the bathroom at 3 A.M.; she was in a dissociated state and was cutting her left breast lightly with a razor blade. Hypnotized for diagnostic purposes, the patient said, "I must suffer as my mother suffered." Her mother had just undergone surgery for breast cancer. This patient also illustrates the defense mechanism of identification, another common hysterical defense (MacKinnon et al. 2006).

One final defense mechanism that may be found in both hysterical and histrionic patients is *emotionality* itself. Becoming intensely, yet superficially and shallowly, emotional may defend against deeper, more heartfelt affects that the patient wishes to avoid (MacKinnon et al. 2006). Knee-jerk emotionality in concert with the global, impressionistic cognitive style serves to keep the histrionic patient from being in touch with any genuine affective states or attitudes toward self and others.

Psychodynamic Understanding

Because a variety of overt behaviors in both genders are subsumed under the categories of hysterical and histrionic personality disorders, a careful psychodynamic assessment is crucial to the informed assignment of the appropriate type of psychotherapy. Female patients with hysterical or histrionic personality styles tend to encounter difficulties at two of the classical psychosexual stages of development: they experience relative maternal deprivation during the oral stage, and they have difficulty resolving the oedipal situation and emerging with a clear sexual identity (Blacker and Tupin 1977). Although both hysterical and histrionic patients have some difficulty with oral and phallic-oedipal issues, the histrionic patient obviously encounters greater difficulty at the earlier stage, whereas the hysterical patient is fixated primarily at the later stage.

In the case of the more primitively organized female patient, the lack of maternal nurturance leads her to turn to her father for the gratification of dependency needs (Blacker and Tupin 1977; Hollender 1971; MacKinnon et al. 2006). She soon learns that flirtatiousness and dramatic exhibitionistic displays of emotion are required to gain her father's attention. As she matures, she learns that she must repress her genital sexuality to remain "daddy's little girl." When the little girl grows up, the primitive neediness characteristic of all her sexual relations may be termed the "breast-penis equation." She often engages in promiscuous sexual behavior that is ultimately unsatisfying because the male penis only serves as a substitute for the maternal breast she unconsciously longs for.

The female with the more neurotic variant has negotiated the oral stage of development with a reasonable degree of success. She, too, is disappointed with her mother, but the disappointment occurs at a more advanced stage of development. In the phallic stage of development directly preceding the full-blown oedipal situation, the little girl must come to terms with the fact that she cannot physically possess her mother as her father can. The goal of the hysterical individual is to be the object of desire to others (Bollas 2000). In the case of the little girl, she may feel she has lost out to her mother and will do whatever she can to become her father's object of desire. Often this may lead to a false self-adaptation in which she suspends her true nature to try to become what others want. Many hysterical women approach men by trying to become what they think the man would most want them to be, and the men end up disappointed because they feel they have been deceived by the woman's phony presentation of herself.

Bollas (2000) noted that hysterical persons tend to erotize a life narrative in which they are the erotic object of someone else. The phenomenon of multiple romantic partners typical of histrionic and hysterical personality disorders often unfolds in a fixed pattern: the chosen romantic man will never be the right one and is therefore expendable. In this way, these women save themselves for the father. As little girls, they often idealized their father, perhaps as the only man worth having. This intense attachment led to rivalrous feelings toward the mother and active wishes to replace her. In the course of therapy or analysis, many hysterical patients recall fantasies of this nature. If they perceive that their brothers are granted special status with their fathers by virtue of their male gender, they also may develop deep resentment and may become highly competitive with men.

Although anorgasmia has classically been associated with hysteria, sexual symptomatology actually is much more varied in patients with hysterical or histrionic personality disorder. Some may have relatively asymptomatic sexual functioning but are cut off from any authentic inner experience of love or intimacy during sexual relations. Sexual body parts may be exhibited through provocative ways of dressing, even though there is little erotic arousal associated with the provocative behavior. In fact, a common occurrence in female hysterical and histrionic patients is surprise when others respond to them as though they are seductive or sexually provocative. In other words, there is a dissociation between the overtly sexualized behavior unconsciously designed to attract attention and the empathic attunement to how it will affect others. All sexuality may be tinged with incestuous meanings because of the oedipal attachment to the father. These women also may choose inappropriate partners as a further defense against giving up oedipal longings. These dynamics are often covert, however, and often only become clear after a careful evaluation. Although some hysterical patients may have

overt, conscious attachments to their father, others will have repressed this dimension of development. Their conscious experience of the father may be tinged with anger as a defense against their underlying longing. Similarly, they may be unaware of their rivalrous feelings toward the mother, whom they consciously love. Evidence of the neurotic dynamics in the hysterical patient may come instead from persistent patterns of triangular relationships, such as falling in love with married men, or from slowly emerging developments in the transference, such as intense rivalry with other female patients. Whether the dynamics are repressed may depend on the father's response to his daughter's oedipal longings. If he views such feelings as unacceptable, he will convey this attitude to his daughter, who will then feel that she must repress them. In homosexual women there may be a negative Oedipus situation—in other words, they felt intense attachment to their mothers while despising their fathers as a rival who always seemed to win the contest for the mother's affection. As a result, they may have a string of female lovers who are otherwise attached and therefore not truly available.

The exaggerated theatrical behavior typical of these patients often relates to a core experience of early childhood that involved not being recognized. In other words, parents who were too self-absorbed, too depressed, or too resentful of their child's developmental needs may have tuned the child out and not recognized the child's internal affective experience. In this regard, caregivers may not have served the necessary containing function to help the child process and metabolize overwhelming and frightening affect states. As Riesenberg-Malcolm (1996) stressed, the hyperbole or exaggeration may be an effort by patients to distance themselves from what is going on internally while also making others take notice of unrecognized emotions.

Many of the developmental dynamics that apply to female patients apply in a similar way to male patients. Whereas hysterical females are often "daddy's girl," many hysterical males have been "mama's boys." They may react to separation-individuation themes in their childhood by erotizing the absent object (Bollas 2000). As soon as the maternal object is away, they imagine their mothers with another man who is preferred over them. Hence many male hysterics of the Don Juan variety are tormented by a combination of separation and exclusion fears (Lubbe 2003). This may lead them into hypermasculine behaviors in which they demonstrate the vanquishing of sexual rivals by systematically seducing women, many of whom are already involved with other men. Like his female counterpart, the hysterical male wishes to be the object of desire, and he may go through one relationship after another seeking the perfect substitute for his mother, only to find that none of them provide the special affirmation he requires.

Other adaptations are possible as well. Some men with this hysterical configuration will choose a celibate lifestyle, such as the priesthood, to un-

consciously maintain unswerving loyalty to their mother. Other boys will deal with their perceived genital inadequacy by indulging in solitary hypermasculine activities such as bodybuilding. Thus they can reassure themselves that they are "real men" with nothing to feel inferior about. Homosexual men may have experienced a negative oedipal situation in which their mothers were perceived as rivals for the father's attention, and they may look for older men to fulfill their longings for a father to whom they could feel close. Indeed, Isay (2009) has pointed out how little boys who are attracted to other boys may experience their fathers as distancing themselves from them because of their failure to conform to their fathers' expectations.

No discussion of hysteria would be complete without reference to incest and childhood seduction. Freud originally believed that many of his hysterical patients had been seduced by their fathers because he so often heard such reports from his patients. He later became convinced that many of these reports were fantasies stemming from oedipal wishes. Amidst the furor over whether Freud's view was correct, many clinicians have adopted an either/or position. Either little girls are actually seduced or they merely fantasize seduction. This dichotomy is further complicated by the fact that many women who have been victimized by incest nevertheless have powerful fantasies about and yearnings for the perpetrator of the incest. Even women who have never been violated by their father may still have powerful conscious or unconscious sexual wishes for him. Finally, there is considerable middle ground where erotized interactions occur that do *not* result in overt incest, but that *do* encourage fantasies.

In terms of the developmental pathogenesis of the neurotic and the more primitive variants of this personality disorder, a history of actual incest is much more likely to be found in the histrionic patient. These patients may go through their adult lives repeating the original trauma by seeking out men who are forbidden in one way or another, such as therapists, married men, or bosses. They may be unconsciously attempting to actively master a passively experienced trauma by being the one to initiate it rather than the one to passively submit.

The higher-level hysterical patient is much less likely to have a history of overt incest but may have had what she perceived as a special relationship with her father. Hysterical patients frequently have a father who was unhappy with his wife and turned to the patient for fulfillment and gratification not possible in the marriage. The patient may receive an implicit message that she must remain loyal to her father forever to rescue him from an unhappy marriage. Fathers in this situation may give subtle or even overt signs of disapproval whenever their daughters show interest in other men. In this scenario, the hysterical patient will find herself surrounded with dynamics

similar to incest, only in attenuated form. Hysterical patients with these dynamics and family constellations may find themselves unable to give up their dependency on their fathers and get on with their lives.

Treatment Approaches

Individual Psychotherapy

Two meta-analyses of psychotherapeutic treatments for personality disorders (Leichsenring and Leibing 2003; Perry et al. 1999) suggest that these conditions respond to both psychodynamic therapy and cognitive-behavioral therapy. However, none of the studies included focused specifically on histrionic personality disorder. Patients with hysterical personality disorder generally respond well to expressive individual psychotherapy or to psychoanalysis. Those with the more primitive organizations require approaches very similar to those used for borderline personality disorder (see Chapter 15). An emphasis on mentalizing, for example, can be of considerable benefit.

Although some patients with hysterical personality disorder will present with a discrete symptom, such as sexual dysfunction, more commonly they enter psychotherapy because of a general dissatisfaction with their relationship patterns. The precipitating event may be the breakup of a marriage or a love relationship. They also may experience vague feelings of depression or anxiety related to disappointment with their current partner (MacKinnon et al. 2006). Unlike many patients with other personality disorders, the patient with hysterical personality disorder readily becomes attached to the therapist and quickly develops a therapeutic alliance in which the therapist is perceived as helpful. The psychotherapy process will generally go well if the therapist adheres to several general principles.

Principles of Technique

A rule of thumb in expressive work is to address resistance before attempting to interpret the underlying content. In the case of the hysterical patient, this axiom dictates that the patient's cognitive style must be dealt with first, because it is so intimately bound up with the patient's defensive configuration. Hysterical patients often begin psychotherapy with an unconscious expectation that the therapist should be able to understand them intuitively, nonverbally, and globally without details of their intrapsychic world (Allen 1977; Gabbard 2014). This expectation is frequently linked to a poignant wish that mother and/or father would have recognized and understood them in childhood. Thus, the expectation of being seen, heard, and understood is fraught with a mixture of hope and disappointment (Riesenberg-Malcolm

1996). These patients fear that their performance will be dismissed or denigrated by the therapist. Indeed, a frequent countertransference reaction to exaggerated displays of emotionality is exactly that sort of contempt. The therapist must appreciate that something important is being communicated in the hyperbolic display of emotion and also that these exaggerated feelings contain a kernel of truth. Something desperate is being communicated to the therapist—something to the effect of "Please recognize me! Please tune in to my pain!"

Even as the therapist empathizes with the affective communication, he or she must also convey to the patient that more detail is needed for a fuller understanding. This approach encourages the patient to begin to articulate in words what is conveyed in feelings. Some carefully planned questions are useful: What does the patient fear? What does the patient want? What are the conflicts that the patient feels (Horowitz 1997)? Is what you are doing in your relationships getting you what you want? If not, what might be more effective? The therapist may also attempt to give words to the patient's feelings based on what he or she observes. This outside perspective (Gabbard 1997) may help patients gain a greater sense of self by internalizing how the therapist views them.

The internal experience of the hysterical or histrionic patient is often that of a leaf in the wind buffeted by powerful feeling states. There may be a complete repression of the ideas that connect one feeling with another. In urging the hysterical patient to reflect on and to attend in detail to internal and external reality, the therapist helps the patient retrieve the ideational connections between feelings. As Allen (1977) noted, part of this process involves teaching the hysterical person to feel with more depth and genuineness. Superficial and shallow feelings defend against more disturbing and more deeply experienced affects. As the patient's tolerance for these deeper feeling states increases, a concomitant increase occurs in the patient's ability to attend to details (Horowitz 1977b).

As patients in the histrionic continuum become able to identify their feelings, attitudes, and ideational states, they develop a greater sense of self-as-agent in effective interaction with the environment rather than self-as-passive-victim of the environment (Horowitz 1977b). These patients often experience vivid visual images and fantasies, but they will not translate these into words unless the therapist assists in this process. Thus, therapists help their patients identify what they want and feel. Patients also learn that having certain thoughts or feelings is not dangerous.

When threatening thoughts and feelings emerge, the more histrionic or primitively organized patients frequently express a wish to know all about the therapist's life. They are highly suggestible, and if therapists share a lot about their own lives and beliefs, their patients will rapidly adopt similar

qualities so as to please their therapists and to thereby avoid the arduous task of getting in touch with their own feelings and beliefs. Therapists should similarly avoid giving a great deal of advice to the neurotically organized hysterical patients because they need to learn that they have considerable resources within themselves with which to approach their problems.

Patients in long-term therapy will find that the process of modifying their cognitive style leads to a modification of object relatedness as well. As these patients begin to attend in more detail to self and others in interpersonal contexts, they develop new patterns of perceiving relationships (Horowitz 1977b). Instead of always seeing themselves as the victim of others, patients begin to understand that they play an active role in perpetuating certain patterns of relating to others. They develop a capacity to compare the actual facts of an interpersonal situation with the internal patterns often superimposed on external situations. Ultimately, the self representation of the passive child so typical of the hysterical patient is replaced by a more mature representation involving activity and sexuality. This transition may take years, however, because patients frequently experience the loss of the hysterical cognitive style as a threat to a basic sense of identity.

In the psychotherapy of the hysterical variant, and to a lesser extent with the more primitive variant, therapeutic work within the transference is a primary vehicle for change. The problems that the patient encounters in relationships outside the therapy will be reproduced within the transference. These patients frequently fall in love and/or experience erotic longings for the therapist. Although psychotherapy can be effective and gratifying with hysterical patients, the mishandling of transference, particularly erotic transference, is a common cause of therapeutic failure. Hence, in this chapter, it is appropriate to provide a comprehensive view of erotic transference, knowing that it is not confined exclusively to patients on the histrionic continuum.

Management of Erotic Transference

Despite the pervasiveness of the phenomenon of erotic transference, not only in hysterical patients but also in others, many therapists do not receive adequate training in the effective and therapeutic management of transference feelings. One female psychiatry resident who was struggling with a male patient's sexual feelings toward her took the problem to her psychotherapy supervisor, an analyst. He responded by scratching his head and replying, "I don't know what you girls do about this problem." Historically, a subtle (or not-so-subtle) sexism has pervaded psychotherapy training programs. Because the vast majority of erotic transference reports in the literature, from Freud to the present, have been of female patients who have fallen in love with their male therapists or analysts, male supervisors have some-

times inadvertently promoted among their male supervisees a casual, denigrating attitude toward female patients who develop an erotic transference. One male resident who was beginning psychotherapy training told his male supervisor that he was uncertain about how to approach his first psychotherapy patient. His supervisor informed him, "It's really very simple. Do you know how to seduce a woman?" The supervisor went on to draw an analogy between "hooking" the patient in a psychotherapy process and seducing a woman. This unprofessional attitude typifies an unfortunate historical trend to "enjoy" the erotic transference rather than analyze and understand it.

Because the term is used loosely to describe a number of different transference developments, a clear definition of the phenomenon is relevant to a discussion of its management. Person (1985) provided a succinct definition that applies to psychotherapy as well as to psychoanalysis:

> The term *erotic transference* is used interchangeably with the term *transference love*. It refers to some mixture of tender, erotic, and sexual feelings that a patient experiences in reference to his or her analyst and, as such, forms part of a positive transference. Sexual transference components alone represent a truncated erotic transference, one that has not been fully developed or is not fully experienced. (p. 161)

In patients with the neurotic or hysterical variant, the erotic transference usually develops gradually and with considerable shame and embarrassment. Sexual longings for the therapist are often experienced as ego-dystonic, and the patient knows that the fulfillment of these wishes would be inappropriate.

The more primitively organized patient on the histrionic spectrum, as well as borderline patients may develop a subtype of erotic transference often termed the *erotized transference* (Blum 1973). In contrast to ordinary transference love, the patient in the throes of an erotized transference makes a tenacious and ego-syntonic demand for sexual gratification. Because of ego impairments in these patients, their internal and external realities are blurred, and they view their expectation of sexual consummation with their therapist as reasonable and desirable. Their seeming obliviousness to the crossing of symbolically incestuous boundaries may stem from a childhood history of being victimized in actual sexual seductions by parents or parental figures (Blum 1973; Kumin 1985–1986).

Because absence is erotized in hysterical patients, psychotherapy is a situation that is inherently stimulating. The absence of physical intimacy in the therapeutic situation, coupled with the repeated separations at the end of each hour, will be regarded as continually exciting by many hysterical patients. Some may even develop what Bollas (2000) has referred to as transference addiction, because the therapy is experienced as an exclusive relationship. These patients may wish for the treatment to go on forever with

no interest in terminating. Many hysterical and histrionic patients will, of course, approach the therapist as a challenge—that is, they wish to become the object of desire for the therapist. Hence, the therapist is meant to be spellbound and swept off his or her feet by the patient, who will go to great lengths in dress, manner, and behavior to try to achieve this end.

The spectrum of transferences ranging from the erotic to the erotized is aptly described by Person (1985) as "both gold mine and minefield" (p. 163). These transferences can set the scene for devastating countertransference acting-out. Therapist–patient sex has severely stigmatized the mental health professions, has ruined the careers of a number of psychiatrists and psychotherapists, and has caused severe psychological damage to the patients who are its victims (Gabbard 1989; Gabbard and Lester 2003; Pope and Bouhoutsos 1986). Surveys reveal that this form of boundary violation is not rare (Gabbard and Lester 2003), so it cannot be dismissed as an occasional aberration of only the seriously disturbed therapist. Many of these unfortunate therapists appear to be both seeking a cure for themselves and making a desperate attempt to cure their patients (Gabbard and Lester 2003).

The "gold mine" aspect of erotic transferences is that they provide the therapist with an in vivo recapitulation of past relationships, as well as a glimpse of common patterns in extratransference romantic relationships in the context of the transference relationship. Thus a patient's problems with love and sexuality can be examined and understood as they develop in a safe relationship where the patient will not be exploited or abused. To mine the gold in the experience without being destroyed by the minefield, therapists may find four principles of technique to be useful (see Table 18–2). Although there are definite gender differences in the expression of erotic transference, I first discuss the handling of erotic transference in general and then examine the specific gender-determined aspects of the phenomenon.

Examination of countertransference feelings. The therapist's countertransference reactions to erotic transference feelings in the patient may represent countertransference narrowly as a reactivation of a relationship in the therapist's past, broadly as an identification with a projected aspect of the patient, or as a mixture of both (Gabbard 2010). Although the patient may well represent a forbidden but sexually arousing object from the therapist's past, the therapist's desire for the patient may also be linked to the actual incestuous desire of a parental figure from the patient's oedipal phase of development. Thus the first step in monitoring countertransference, in keeping with the practice of dynamic psychiatry, is for therapists to assess the relative weight of their own contributions versus those of the patient. Therapists who attempt to manage erotic transference in intensive psychotherapy without a personal treatment experience, however, will be at a serious disadvantage.

TABLE 18–2. Therapeutic management of erotic transference

1. Examine countertransference feelings.
2. Accept, in a nonexploitative way, erotic transference as important therapeutic material to be understood.
3. Assess the multiple meanings of the transference in its function as a resistance to a deepening of the therapeutic process.
4. Interpret connections between transference and both current and past relationships.

Several common countertransference patterns relate to erotic transference. The first, common in male residents treating attractive female patients, is to see erotic transference where none exists. Male therapists may respond to their own sexual arousal by projectively disavowing it and instead seeing it in their patients, whom they label as "seductive." In these circumstances, the resident who is pressed for details about why the patient is seductive or why she is sexually interested in him is often at a loss to present convincing evidence. Because of anxieties about his own sexual feelings, he has avoided them, much as the hysterical patient attempts to avoid her sexual feelings. Although this avoidance may simply reflect beginner's anxiety about having sexual feelings in psychotherapy, it may also be a repetition of the patient's father's response to his own sexual desire for his daughter (Gorkin 1985).

Another possibility is that the projective disavowal of the therapist's own sexual feelings for the patient may subtly influence the patient to develop an erotic transference. The constructivist perspective emphasizes the continuous influence of the therapist's subjectivity on the patient's transference. Erotic transference, in particular, may reflect significant contributions from the therapist (Gabbard 1996). These contributions can involve a variety of factors, including the therapist's expectations, the therapist's needs, the therapist's theoretical viewpoint, the therapist's countertransference, and even quotidian elements like the therapist's gender, physical appearance, and age. All of these factors may partly determine how the patient sees the therapist, and ongoing self-scrutiny will help the therapist sort out what is coming from the patient and what derives from the therapist's influence on the patient. Patients on the hysterical-histrionic continuum are highly suggestible, and if they believe that the therapist wants them to fall in love in the transference, they may readily comply.

A second countertransference reaction is cold aloofness in response to the patient's confessions of erotic longings for the therapist (MacKinnon et al. 2006). To control any sexual countertransference reactions to the patient's feelings, the therapist may become more silent, less empathic, and

more distant. This "straitjacketing" of all emotions helps to rigidly maintain control of sexual impulses that seem threatening.

A third common countertransference reaction is anxiety stemming from the fear that sexual feelings—either in the patient or in the therapist—will get out of control. This anxiety may lead the therapist to divert the conversation from the patient's expressions of love or sexual arousal or to interpret such feelings prematurely as "resistance," a digression from the therapeutic task. When a male therapist inappropriately tells his female patient that he will not allow the therapy to be sidetracked by her feelings for him, he may inadvertently coerce her to stick to the problems outside therapy that brought her to treatment. Such anxious attempts to eliminate erotic transference feelings may give patients the message that sexual feelings are unacceptable and possibly disgusting, a view that often mirrors feelings of these patients. The therapist's own underlying disgust relates to the covert message in intense erotic transference that therapy is useless—that only sex or "love" can cure (Gorkin 1985).

In the fourth countertransference pattern, which may be more insidious than the others, therapists may encourage and foster erotic feelings for their personal gratification. These therapists, who listen with voyeuristic delight to the details of their patient's sexual fantasies, may have been drawn to the profession because they long to be idealized and loved. Underneath this wish, they may gain sadistic pleasure from arousing their patients' futile sexual wishes. This pattern can often be traced to these therapists' childhood interactions, in which they felt they were aroused by the opposite-sex parent only to be frustrated. By practicing psychotherapy, these individuals may be trying to reverse that childhood situation. Thus therapists must be aware of their own desires in the therapeutic relationship. As Kumin (1985–1986) noted, "Both the analyst's capacity and incapacity to interpret accurately the patient's wishes in the transference requires an appreciation of not only what and whom the patient desires but also what and whom the analyst desires" (p. 13). Kumin also suggested that the desires of the therapist for the patient may present a more formidable resistance than do the patient's desires for the therapist. Numerous psychotherapy processes have become stalemated in the throes of intense erotic transference because the therapist has been too busy basking in the glow of sexual feelings. We must remember that we can all be masters of self-deception when it comes to rationalizing the need to push the boundaries to the breaking point because in a particular case it is in the patient's best interests to do so (Gabbard and Hobday 2012).

Nonexploitative acceptance of erotic transference as important therapeutic material to be understood. A therapist may wish to convey to the patient that sexual or loving feelings are acceptable aspects of the therapeutic expe-

rience. The therapist may make an educational comment such as "In psychotherapy you are likely to experience a broad range of feelings—hate, love, envy, sexual arousal, fear, anger, and joy—all of which must be dealt with as acceptable topics for discussion and as carriers of important information for the therapy." Although it is true that erotic transference may serve as resistance to the emergence of other material in the therapy, it is usually a technical error to immediately interpret such feelings as resistance. To understand what is being repeated from the past, the erotic transference must be allowed to develop fully.

Freud (1914/1958) first used the term *acting-out* to describe a patient's tendency to repeat in action something from the past rather than remember and verbalize it. Patients can be told that the feelings developing in the therapy will provide important information about feelings that develop in their other relationships, both past and present. If a patient insists on having the therapist gratify the transference wishes, the therapist can point out that not gratifying the wishes can lead to a better understanding of what happens in other relationships. The therapist should keep in mind that erotic transference may be intensely unpleasant for the patient (just as it may be for the therapist), not only because of the frustration it brings but also because it may be embarrassing. The therapist may wish to communicate an empathic understanding of the patient's shame: "I know it is difficult and painful for you to have these feelings and actually discuss them with me, but if we can explore them together we may be able to help you understand more fully the problems that brought you here."

Therapists must remember that from the patient's perspective, the transference feelings are profoundly real. Hence, efforts to dismiss them by suggesting that the feelings are not "real" are likely to backfire. The patient may feel misunderstood, invalidated, and humiliated.

Assessment of the multiple meanings of the transference in its function as a resistance. Erotic transference is a resistance in the sense that something is being repeated rather than remembered and verbalized. Resistance should not be equated, however, with "something bad that must be removed immediately," as it often is by beginning therapists (Gabbard 2010). As just noted, erotic transference is also an important communication that should be understood. Like all other mental phenomena, erotic transference is determined by the principle of multiple function. It should not be taken simply at face value but rather should be explored via the patient's associations, dreams, and memories for all of its multiple meanings, some of which may be unconscious. In the psychotherapeutic setting, there is considerable fluidity of gender and sexual orientation (Gabbard and Wilkinson 1996). For example, a male patient's erotic transference to a female therapist may represent passive

homosexual longings even though the therapist is of the opposite sex (Torras de Bea 1987). Because erotic transference must also be understood in terms of its function at a particular moment in therapy, the therapist must assess what preceded its development and what follows its flourishing.

> One male patient began his therapy session with his male therapist by saying that he had been helped enormously in the previous session by the therapist's explanation. After commenting on how much the therapist's interpretation had helped him at work, the patient began to contradict what he had just said by maintaining that his relationships were deteriorating. As he continued to talk, he revealed that he had been having sexual fantasies about the therapist and that he believed the therapist could only help him by ejaculating semen into his rectum to make him more masculine. The therapist pointed out that the patient was devaluing the help of the insights that he had received in the previous session by holding onto a magical belief that a sexual liaison was the only way to be helped. The patient acknowledged that he needed to devalue the therapist's help because he felt so inferior to the therapist, who he said was "on Mt. Olympus." The therapist then explained that the patient's envy had increased as he was helped, so he had sexualized the transference to devalue the help. (If the therapist's insights were not particularly effective or useful, there was much less to envy.) In response, the patient said that his liberating feelings of having been helped had alternated with feelings of humiliation because he had to acknowledge that the therapist knew something the patient did not know, which made him feel vulnerable.

In this instance, the patient's erotic transference was a way to defend against his envy of the therapist's competence by devaluing it. Sexualization in the transference may be a way to defend against other feelings as well.

> A male patient was seeing his female therapist for the last time prior to her departure at the end of her residency training program. He told her that he had seen a movie the night before in which a female psychiatrist had kissed one of her male patients. He observed that the patient had seemed to benefit from the therapist's affection, and he asked his therapist if she might do the same with him. After an initially anxious reaction to the request, the therapist asked if the unexpected request might be related to the termination of the therapy. The patient responded that he would rather not think about that subject. The therapist then pointed out to the patient that his wish to sexualize their relationship might be a defense against facing the grief associated with termination.

Sexualizing the end of a relationship is a common phenomenon (in therapy and in life in general). It serves to avoid the mourning process connected with loss of an important figure. In this vignette, the patient's wish to become physically involved with his therapist was also a way to deny the definitive nature of termination: A kiss might lead to a beginning rather than an ending. Indeed, many cases of therapist–patient sexual boundary viola-

tions occur around the time of termination (Gabbard and Lester 2003). Sexualization can be a manic defense against loss that leads the two members of the therapeutic dyad to engage in mutual denial. Both can think to themselves: "This is not over—it's simply being transformed into something else."

Therapists who view transference love as a natural and understandable response to their enormous sexual appeal are overlooking the darker side of erotic transference. Hostility often lies just beneath the surface of a patient's transference love. Indeed, erotic transferences frequently mask considerable aggression and sadism (Kumin 1985–1986). Exploration of transference wishes for a sexual relationship regularly reveals wishes to hurt, embarrass, or destroy the therapist. A patient's demands for sexual boundary crossing may be so tormenting, especially in instances of the erotized variant typical of histrionic and borderline patients, that the therapist dreads each session. The therapist may feel used and transformed into a need-gratifying object whose only function is to fulfill the patient's inappropriate demands (Frayn and Silberfeld 1986).

> Ms. KK was a 24-year-old homosexual patient who was typical of patients who are on the histrionic end of the hysterical-histrionic continuum. She had a history of sexual abuse by male relatives. She formed an intense erotized transference to her female therapist almost immediately. She flirted with her provocatively in the sessions by touching the therapist's foot lightly with her own foot and asking, "Does this make you nervous?" Ms. KK steadfastly maintained that her therapist could only get to know her if she slept with her. She also demanded to know her therapist's sexual orientation. Although the therapist frustrated the patient's wish to destroy their professional relationship by transforming it into a sexual one, the patient continued her efforts at seduction. The patient would regularly bring in explicit sexual fantasies about her therapist:
>
> "I am caressing your body—your back, your hips, your thighs. I gently and quickly stroke my hand across your pussy. You moan softly and tighten your grip across my back. I kiss you and whisper softly in your ear that I'm going to make love to you. I softly massage your breasts and kiss them. I kiss your stomach and move down toward your pussy. I kiss the inside of your thighs while stroking your clitoris with my tongue. I continue to kiss, suck, and caress you with my tongue. You moan with pleasure as you have an orgasm. I kiss your thighs again and lightly squeeze your breasts and run my fingers down your sides to your hips. I begin to lick at your clitoris again and stick my tongue inside you. I then lick and suck on your clitoris while I gently ease one, then two of my fingers into you. You have a long, multiple, satisfying orgasm which ends with you stroking my hair and me lightly kissing your pussy."
>
> Needless to say, the patient's expression of such fantasies made the therapist feel uncomfortable and anxious, as well as controlled. If she interrupted the fantasies, she felt that she was revealing her discomfort and disapproval of the patient's transference feelings. If she remained silent, she felt that she was colluding in an exhibitionist–voyeur pairing.

> The patient finally revealed some of the underlying aggressive feelings that were masquerading as erotized transference. She commented to the therapist, "You know I'm aware of still wanting to piss you off. Probably force you into rejecting me. Make you hate me. Am I succeeding? I really want you to like me. But since I know that's out of the question, I'll just drive you away. It's the shits, isn't it? You see, I see our relationship in two ways: either we fuck, or I make you hate my guts."

To a large extent, Ms. KK had induced a paralysis in the therapist, who felt cruel and sadistic by frustrating the patient's wishes. A consultation helped the therapist understand that she was being controlled by a projective identification process so that the normal professional limits of psychotherapy seemed ruthless and unreasonable. In other words, a cold, depriving object from the patient's past had been projected onto the therapist, who unconsciously identified with this projected material. Moreover, her own anger at the patient for her relentless control of the therapy also contributed to her feeling that any intervention would appear cold and ruthless.

As the psychotherapy continued, it became clearer that the overt sexual wish was only the tip of an iceberg. During one session, Ms. KK reported a dream in which she was in a high-tech office. There was a machine that could translate the patient's thoughts, so that she did not have to tell them to her therapist. In the patient's associations to the dream, she acknowledged that her longings for the therapist were not truly sexual but rather a wish for her therapist to really know her intimately. The therapist eventually helped Ms. KK to see that her wish for sex contained a wish for merger—a wish that her therapist would know her thoughts without her having to voice them. This regressive longing to return to the mother–infant symbiotic state is often a powerful component of erotic or erotized transferences in the female patient–female therapist dyad. The sexualized wish may be preferable to the more threatening wish for merger.

Interpretation of connections between transference and both current and past relationships. An interpretation that illuminates the meanings and functions of erotic transference will often reduce the desire and the resistance inherent in transference love (Kumin 1985–1986). To avoid premature interpretation, the therapist may need to silently formulate the interpretation to help with countertransference desires. It is often wise to speak the words of the interpretation silently to oneself four times before delivering the interpretation to the patient. The timing of transference interpretations is a matter of judgment (Gabbard 2010). One guideline is to avoid interpreting it until the underlying linkages to past relationships and to current extratransference relationships are near conscious awareness. The therapist can use the model of the triangle of insight described in Chapter 4 to con-

struct connections between the transference feelings and past relationships, as well as between the transference and current extratransference relationships. By pointing out that transference love is a repetition of something from the past, and by asking the patient if the situation is reminiscent of past situations, the therapist can lay the groundwork for interpretive interventions. However, one must avoid the implication that the feelings are really for someone else rather than for the therapist. A more effective course is to help these patients understand that the love they feel for the therapist is both real and displaced, in the sense that it derives in part from feelings that were experienced toward objects from the past (Gabbard 1996).

An actual transcript of a psychotherapy session may illustrate some of the technical approaches to interpreting erotic transference.

Ms. LL was a 26-year-old married patient with a neurotically based hysterical personality disorder. She was seen twice weekly by a male therapist in expressive-supportive psychotherapy with a predominantly expressive emphasis. She began psychotherapy with complaints of anorgasmia, headaches, constant marital difficulties, fear of "standing on her own two feet," feelings of being unloved and unwanted, and a generalized concern that she was too dependent. Midway through the second year of treatment, the following exchange occurred in one session:

Ms. LL: My husband and I haven't been getting along. We don't see each other much, and when we do, we argue. I wanted to make you a buddy again today, but when I walked in, something changed. I don't know what to say today. I'd like to get real mad at you, but I don't know why. Probably because I need attention, and my husband's not giving me any. When I don't have anything to say, it's usually because I have feelings for you—I had butterflies just now when I said that. There are two kinds of feelings I get in here—one is when I feel that you're like my dad and I want you to cradle me and give me the pat on the back. The other is when I want you to hold me real tight… (*patient stops*)

Therapist: You had a feeling just now that stopped you in midsentence. What was it?

Ms. LL: I don't want to say it. It's ridiculous. (*with great hesitation*) I can't just come in here…and look at you…and think, "I want to make love with you." I can't feel that way. That's not me.

Therapist: To think that you could have sexual feelings is so unacceptable to you that you cannot own the feelings as yours?

Ms. LL: I'm just not like that. Not even with my husband. My subconscious wants to hang on to you and hold you tightly, but my conscious mind wants to pretend I don't have the feelings. I'd rather go back to just having the feeling that you were like my dad and I need a pat on the back.

THERAPIST: It's particularly unacceptable for you to have sexual feelings for someone that you also view as a dad. I wonder if the same thing happened as a little girl in your relationship with your father.

MS. LL: I was always very special to my dad. When he walked me down the aisle and gave me away at the wedding, he told me that I was always his favorite of his three daughters. I shouldn't be talking like this. I have to go out and get in the car with my husband and spend the evening with him, but my thoughts are going to be about you.

THERAPIST: It sounds like there is a similarity between your attachment to me and your attachment to your dad in that both make it difficult for you to invest emotionally in your husband.

In this vignette, the therapist draws a connection between the patient's erotic transference and her feelings for her father. Sexual feelings are forbidden in both relationships because she sees them as incompatible with her otherwise paternal view of the therapist and her father. After linking the transference feelings to the patient's past relationship with her father, the therapist connects these longings to her difficulty with her husband, a current extratransference relationship.

Even experienced therapists often feel discombobulated by expressions of love and desire from a patient. As poets have long known, passion clouds judgment. By their very nature, feelings of love and/or lust tend to evoke enactments in both patient and therapist (Gabbard 1994). In other words, both persons are prone to lose their reflective awareness of the transferential and countertransferential characteristics of the feelings because they seem so real and compelling. Therapists must carefully monitor deviations from their standard clinical practice as a way of alerting themselves to countertransference enactment. Several warning signs are particularly useful in this form of boundary monitoring (Gabbard 2003): extending sessions beyond their usual length, reducing the fee or not charging the patient, self-disclosing about one's personal life to the patient, daydreaming constantly about the patient, paying careful attention to one's appearance on the day of the patient's appointment, hugging the patient or engaging in other forms of physical contact, wishing to meet the patient in a nonclinical setting, and imagining that one can rescue the patient from his or her misery (Gabbard and Wilkinson 1994; Gutheil and Gabbard 1993). When therapists begin to observe that they are deviating along these lines or being swept away by erotic feelings toward the patient, they would be wise to seek out consultation or supervision from a respected colleague. Indeed, it is probably wise for all therapists to make regular use of consultation when they are treating a patient with an erotic transference or experiencing erotic countertransfer-

ence (Gabbard 1996, 2003; Gabbard and Lester 2003). Moreover, sexual feelings in the dyad may be "out of sync," and desire may oscillate back and forth between the therapist and patient and only occasionally reside in both together.

Therapists must also be aware that not all patients experiencing sexual feelings toward the therapist will respond to interpretive efforts. More primitively organized patients may translate their feelings into action and throw themselves at the therapist's feet, sit on the therapist's lap, or passionately hug the therapist as they move toward the office door. In such cases, the therapist must set firm limits. Patients may need to be told that they must return to their chairs and that physical contact is off-limits. Sometimes an educational comment is helpful as well: "Psychotherapy is a verbal treatment that can only work under certain circumstances. One of those circumstances is that you sit in your chair and I sit in mine."

Gender Differences in Erotic Transference

The overwhelming majority of case reports in the literature involving erotic or erotized transferences are of female patients with male therapists (Lester 1985). However, it is not at all rare in other gender constellations. Gornick (1986) noted that some male patients find it much more unacceptable to be passive and dependent vis-à-vis a female than to express direct sexual feelings. The shame of being dependent may lead certain male patients to defend against such feelings by "turning the tables" and using sexual feelings in the transference to restore a sense of male dominance.

When a female therapist is treating a male patient, another gender difference is apparent—namely, the risk of assault. Female therapists, as a general rule, are more likely to experience a threat to their safety than a male therapist would (Celenza 2006; Hobday et al. 2008). If the male patient has a serious antisocial or borderline personality disorder and poor impulse control, a female therapist may be in danger in a locked office. Interpreting transference to an aggressive and impulsive patient may be of no use whatsoever, and limits must be clearly set. In some cases, treatment may even need to be terminated, because it is not possible to work in a context where there is threat of assault. Female therapists must make a careful determination whenever erotic or erotized transferences appear in a male patient (Gabbard 2010). Some male patients feel inhibited about bringing up sexual feelings with a female therapist and may initiate affairs with women they know as a displacement of their transference feelings (Person 1985). Others use crudely sexual comments to unsettle the therapist and gain the upper hand in the therapeutic dyad. Female therapists must contemplate specific questions when erotic feelings emerge in therapy. Can this patient use sexual fan-

tasy productively by keeping it in the realm of fantasy and exploring its meaning? Or is talking about the sexual fantasy likely to lead to some form of action where the male patient believes that the female therapist is inviting actual sexual contact? In other words, would the patient misinterpret exploration as an enactment?

Because so many more case reports of female patients with erotic transference have appeared in the literature, Person (1985) observed that clinicians might get the impression that sexual feelings in therapy are specifically and exclusively related to the psychology of women. However, although many male patients being treated by a male therapist may suppress or deny erotic transference because of homosexual anxieties, some do develop full-blown erotic or erotized transference to their male therapist that needs to be systematically understood and interpreted. In many cases, the sexualized transference is a defense against more uncomfortable feelings of love and longing that are difficult to express (Gabbard 1994).

Group Psychotherapy

Clinicians have often noted that patients who are good candidates for dynamic individual psychotherapy are also good candidates for dynamic group psychotherapy. Such is the case with hysterical patients, who often become "stars" in their groups. They are highly valued by other group members for their ability to express feelings directly and for their care and concern about others in the group. The hysterical patient's cognitive style and its associated defenses of repression and denial can be dealt with quite effectively in group psychotherapy. Other patients in the group will help hysterical patients see how they tend to distort their view of self and others by omitting details from interactional situations. For example, when one female hysterical patient described how she was misunderstood as being seductive when she was simply being friendly with a man at work, male patients in the group pointed out that she might be overlooking what she had said (or how she had said it) in the interaction. Furthermore, they pointed out how this patient behaved similarly in the group itself and how she seemed oblivious to the flirtatious signals she gave men in the group as well.

Hysterical patients generally form a positive maternal transference to the group as a whole. They seize group therapy as an opportunity to receive some of the maternal nurturance that they believe they missed during childhood. They are therefore well motivated to attend group therapy and to encourage others to view it as a valuable resource. Histrionic patients, however, can be more problematic in groups, because they will often "upstage" other patients by demanding to be the center of attention through florid displays of emotionality. Such patients can be effectively treated in group psychother-

apy only if they are also in individual psychotherapy, much as with group psychotherapy of borderline patients (see Chapter 15).

Concluding Remarks

The histrionic to hysterical continuum encompasses a range of character pathology with an array of strengths and weaknesses in patients situated along that continuum. Prior to developing a treatment plan, one must first assess the patient in terms of hysterical versus histrionic features and the considerations regarding suitability for expressive versus supportive therapy that follow from that assessment. These patients can be gratifying for the therapist, and one must be wary of overlooking negative transference that lurks behind the wish to please the therapist. Like those with narcissistic personality disorder, some histrionic patients may place inordinate emphasis on their personal appearance and capacity to attract others. Hence the decline in their ability to fascinate may be associated with depressive tendencies, but it may also make them more authentic in their affective expression. On the other hand, this decline in youthfulness and sex appeal can lead them to become even more desperate in their sexualization of the therapeutic relationship. Therapists must be sensitive to the narcissistic wounding inherent in this developmental crisis and help them see that they have depth to them beyond physical appearance and sexual desirability.

References

Allen DW: Basic treatment issues, in Hysterical Personality. Edited by Horowitz MJ. New York, Jason Aronson, 1977, pp 283–328

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Bakkevig JF, Karterud S: Is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, histrionic personality disorder category a valid construct? Compr Psychiatry 51:462–470, 2010

Baumbacher G, Amini F: The hysterical personality disorder: a proposed clarification of a diagnostic dilemma. Int J Psychoanal Psychother 8:501–532, 1980–1981

Blacker KH, Tupin JP: Hysteria and hysterical structures: developmental and social theories, in Hysterical Personality. Edited by Horowitz MJ. New York, Jason Aronson, 1977, pp 95–141

Blagov PS, Westen D: Questioning the coherence of histrionic personality disorder: borderline and hysterical subtypes in adults and adolescents. J Nerv Ment Dis 196:785–797, 2008

Blum HP: The concept of erotized transference. J Am Psychoanal Assoc 21:61–76, 1973

Bollas C: Hysteria. London, Routledge, 2000

Cale EM, Lilienfeld SO: Histrionic personality disorder and antisocial personality disorder: sex-differentiated manifestations of psychopathy? J Pers Disord 16:52–72, 2002

Celenza A: The threat of male-to-female erotic transference. J Am Psychoanal Assoc 54:1207–1231, 2006

Chodoff P: The diagnosis of hysteria: an overview. Am J Psychiatry 131:1073–1078, 1974

Chodoff P, Lyons H: Hysteria, the hysterical personality and "hysterical" conversion. Am J Psychiatry 114:734–740, 1958

Cleghorn RA: Hysteria: multiple manifestations of semantic confusion. Can Psychiatr Assoc J 14:539–551, 1969

Easser BR, Lesser SR: Hysterical personality: a re-evaluation. Psychoanal Q 34:390–405, 1965

Frayn DH, Silberfeld M: Erotic transferences. Can J Psychiatry 31:323–327, 1986

Freud S: Remembering, repeating and working-through (further recommendations on the technique of psycho-analysis II) (1914), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 145–156

Gabbard GO (ed): Sexual Exploitation in Professional Relationships. Washington, DC, American Psychiatric Press, 1989

Gabbard GO: On love and lust in erotic transference. J Am Psychoanal Assoc 42:385–403, 1994

Gabbard GO: Love and Hate in the Analytic Setting. Northvale, NJ, Jason Aronson, 1996

Gabbard GO: A reconsideration of objectivity in the analyst. Int J Psychoanal 78:15–26, 1997

Gabbard GO: Miscarriages of psychoanalytic treatment with suicidal patients. Int J Psychoanal 84:249–261, 2003

Gabbard GO: Long-Term Psychodynamic Psychotherapy: A Basic Text, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2010

Gabbard GO: Histrionic personality disorder, in Gabbard's Treatments of Psychiatric Disorders, 5th Edition, Washington, DC, American Psychiatric Publishing, 2014

Gabbard GO, Hobday GS: A psychoanalytic perspective on ethics, self-deception, and the corrupt physician. Br J Psychother 28:221–234, 2012

Gabbard GO, Lester EP: Boundaries and Boundary Violations in Psychoanalysis. Washington, DC, American Psychiatric Publishing, 2003

Gabbard GO, Wilkinson SM: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press, 1994

Gabbard GO, Wilkinson SM: Nominal gender and gender fluidity in the psychoanalytic situation. Gender and Psychoanalysis 1:463–481, 1996

Gorkin M: Varieties of sexualized countertransference. Psychoanal Rev 72:421–440, 1985

Gornick LK: Developing a new narrative: the woman therapist and the male patient. Psychoanalytic Psychology 3:299–325, 1986

Gutheil TH, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk management dimensions. Am J Psychiatry 150:188–196, 1993

Gutierrez F, Vall G, Peri JM, et al: Personality disorder features through the life course. J Pers Disord 26:763–774, 2012

Halleck SL: Hysterical personality traits: psychological, social, and iatrogenic determinants. Arch Gen Psychiatry 16:750–757, 1967

Hamburger ME, Lilienfeld SO, Hogben M: Psychopathy, gender, and gender roles: implications for antisocial and histrionic personality disorders. J Psychother Pract Res 10:41–55, 1996

Hobday GS, Mellman L, Gabbard GO: Complex sexualized transferences when the patient is male and the therapist female. Am J Psychiatry 165:1525–1530, 2008

Hollender M: Hysterical personality. Comment on Contemporary Psychiatry 1:17–24, 1971

Horowitz MJ: The core characteristics of hysterical personality (Introduction), in Hysterical Personality. Edited by Horowitz MJ. New York, Jason Aronson, 1977a, pp 3–6

Horowitz MJ: Structure and the processes of change, in Hysterical Personality. Edited by Horowitz MJ. New York, Jason Aronson, 1977b, pp 329–399

Horowitz MJ: Psychotherapy for histrionic personality disorder. J Psychother Pract Res 6:93–107, 1997

Horowitz MJ: Histrionic personality disorder, in Treatments of Psychiatric Disorders, Vol 2, 3rd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2001, pp 2293–2307

Isay R: Becoming Gay: The Journey to Self-Acceptance. New York, Owl Books, 2009

Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975

Klonsky ED, Jane JS, Turkheimer E, et al: Gender role and personality disorders. J Pers Disord 16:464–476, 2002

Kolb LC: Noyes' Modern Clinical Psychiatry, 7th Edition. Philadelphia, PA, WB Saunders, 1968

Kumin I: Erotic horror: desire and resistance in the psychoanalytic situation. Int J Psychoanal Psychother 11:3–20, 1985–1986

Lazare A: The hysterical character in psychoanalytic theory: evolution and confusion. Arch Gen Psychiatry 25:131–137, 1971

Leichsenring F, Leibing E: The effectiveness of psychodynamic therapy and cognitive-behavioral therapy in the treatment of personality disorders: a meta-analysis. Am J Psychiatry 160:1223–1232, 2003

Lerner HE: The hysterical personality: a "woman's disease." Compr Psychiatry 15: 157–164, 1974

Lester EP: The female analyst and the erotized transference. Int J Psychoanal 66:283–293, 1985

Lubbe T: Diagnosing a male hysteric: Don Juan-type. Int J Psychoanal 84:1043–1059, 2003

Luisada PV, Peele R, Pitard EA: The hysterical personality in men. Am J Psychiatry 131:518–521, 1974

MacKinnon RA, Michels R, Buckley PJ: The Psychiatric Interview in Clinical Practice, 2nd Edition. Washington, DC, American Psychiatric Publishing 2006

Malmquist C: Hysteria in childhood. Postgrad Med 50:112–117, 1971

Marmor J: Orality in the hysterical personality. J Am Psychoanal Assoc 1:656–671, 1953

Mitchell J: Madmen and Medusas. London, Penguin, 2000

Perry JC, Barron E, Ianni F: Effectiveness of psychotherapy for personality disorders. Am J Psychiatry 156:1312–1321, 1999

Person ES: The erotic transference in women and in men: differences and consequences. J Am Acad Psychoanal 13:159–180, 1985

Pope KS, Bouhoutsos JC: Sexual intimacy between therapists and patients. New York, Praeger, 1986

Riesenberg-Malcolm R: "How can we know the dancer from the dance?" Hyperbole in hysteria. Int J Psychoanal 77:679–688, 1996

Shapiro D: Neurotic Styles. New York, Basic Books, 1965

Sugarman A: The infantile personality: orality in the hysteric revisited. Int J Psychoanal 60:501–513, 1979

Torras de Bea E: A contribution to the papers on transference by Eva Lester and Marianne Goldberger and Dorothy Evans. Int J Psychoanal 68:63–67, 1987

Trull TJ, Seungmin J, Tomko RL, et al: Revised NESARC personality disorder diagnoses: gender, prevalence, and comorbidity with substance dependence disorders. J Pers Disord 24:412–426, 2010

Wallerstein RS: Diagnosis revisited (and revisited): the case of hysteria and the hysterical personality. Int J Psychoanal Psychother 8:533–547, 1980–1981

Zetzel ER: The so called good hysteric. Int J Psychoanal 49:256–260, 1968

CHAPTER
19

CLUSTER C PERSONALITY DISORDERS

Obsessive-Compulsive, Avoidant, and Dependent

The three personality disorders classified in Cluster C of DSM-5 (American Psychiatric Association 2013)—obsessive-compulsive, avoidant, and dependent—are grouped together because persons with these disorders usually have anxiety or fear in common as a prominent characteristic. These disorders are also characterized by intrapsychic conflict about painful feelings toward oneself and others. In psychotherapy research obsessive-compulsive, avoidant, and dependent personality disorders are often studied together, and there is a growing database suggesting that all three disorders improve with dynamic psychotherapy (Perry 2014).

Obsessive-Compulsive Personality Disorder

OCPD is a common disorder. In the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (Grant et al. 2004), OCPD was found to be the most prevalent personality disorder in the general population, at 7.88%. However, it is commonly confused with obsessive-compulsive disorder (OCD).

The distinction between OCD (or obsessive-compulsive neurosis) and OCPD is based on the difference between symptoms and enduring character traits. As described in Chapter 9, the patient with OCD is plagued with recurring unpleasant thoughts and is driven to perform ritualistic behaviors. These symptomatic manifestations are generally ego-dystonic in that the patient recognizes them as problems and ordinarily wishes to be rid of them. In contrast, the traits that constitute the DSM-5 diagnosis of OCPD (Box 19–1) are lifelong patterns of behavior that may be ego-syntonic. These traits do not necessarily cause distress in the patients themselves and may even be regarded as highly adaptive. Indeed, studies of physicians suggest that certain obsessive-compulsive characteristics contribute significantly to success as a physician (Gabbard 1985; Vaillant et al. 1972). The unswerving devotion to work typical of the obsessive-compulsive person also leads to high achievement in professions other than medicine in which attention to detail is essential. However, success in the work sphere often comes at a high price to these people. Their significant others often find them difficult to live with and frequently instigate their coming to psychiatric attention.

Although the distinctions between OCD and OCPD in DSM-5 are clear and useful, there is some controversy regarding the extent of the overlap between these two diagnostic entities. Symptoms of an obsessive-compulsive nature have also been reported as transitory occurrences during the psychoanalytic treatment of patients with OCPD (Munich 1986). However, empirical studies indicate that a wide range of personality disorders may occur in patients with OCD. In one study, fewer than half the patients with OCD satisfied the criteria for OCPD (Rasmussen and Tsuang 1986). In fact, the most common characterological diagnosis in this sample was a mixed personality disorder with avoidant, dependent, and passive-aggressive features. In a study (Baer et al. 1990) that assessed 96 patients with OCD, only 6% had a diagnosis of OCPD. Other investigations have found that OCPD is significantly more common in patients with OCD than in those with panic and major depressive disorder (Diaferia et al. 1997) and that obsessional symptoms are more likely to be associated with traits of OCPD than with traits of other personality disorders (Rosen and Tallis 1995). In a Scandinavian study of comorbidity between OCD and personality disorders (Bejerot et al. 1998), 36% of OCD patients were also diagnosed with OCPD. A controlled study that included 72 OCD patients and 198 first-degree relatives (Samuels et al. 2000) found a comparatively high prevalence of OCPD in families of OCD patients, suggesting that there may be some common familial etiology of OCPD and OCD. Despite the uncertainty about whether the two conditions are actually related, OCPD and OCD are usually discussed separately because the treatment implications for the two are quite different.

Box 19–1. DSM-5 Criteria for Obsessive-Compulsive Personality Disorder

301.4 (F60.5)

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
4. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
8. Shows rigidity and stubbornness.

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Psychodynamic Understanding

Early psychoanalytic contributions (Abraham 1921/1942; Freud 1908/1959; Jones 1948; Menninger 1943) connected certain character traits—particularly obstinacy, parsimony, and orderliness—with the anal phase of psychosexual development. Patients with these personality features were viewed as having regressed from the castration anxiety associated with the oedipal phase of development to the relative safety of the anal period. Driven by a punitive superego, they presumably employed characteristic defensive operations of the ego, including isolation of affect, intellectualization, reaction formation, undoing, and displacement (see Chapter 2). Their obsessive orderliness, for example, was conceptualized as a reaction formation against an underlying wish to engage in anal messiness and its derivatives. The considerable difficulty that the person with an obsessive-compulsive personality has in expressing aggression

was related to early power struggles with maternal figures around toilet training. The stubbornness of the obsessive individual could also be viewed as an outgrowth of those same struggles.

Modern contributions (Gabbard 1985; Gabbard and Menninger 1988; Gabbard and Newman 2005; Horowitz 1988; Josephs 1992; McCullough and Maltsberger 2001; Salzman 1968, 1980, 1983; Shapiro 1965) have gone beyond the vicissitudes of the anal phase to focus on self-esteem issues, affect phobia, perfectionism, interpersonal issues, absence of fun or pleasure, balancing work and love relationships, and efforts to control oneself and others. Individuals with OCPD have a good deal of self-doubt. As children, they did not feel sufficiently valued or loved by their parents. In some cases, this perception may relate to actual coldness or distance in parental figures, whereas in others the children may simply have required more reassurance and affection than the ordinary child to feel a sense of parental approval. Psychodynamic treatment of these patients reveals strong, unfulfilled dependent yearnings and a reservoir of rage directed at the parents for not being more emotionally available. Because obsessive-compulsive patients find both anger and dependency consciously unacceptable, they defend against those feelings with defenses such as reaction formation and isolation of affect. In a counterdependent effort to deny any dependency on anyone, many obsessive-compulsive persons go to great lengths to demonstrate their independence and their "rugged individualism." Similarly, they strive for complete control over all anger, and they may even appear deferential and obsequious to avoid any impression of harboring angry feelings.

Intimate relationships pose a significant problem to the obsessive-compulsive patient. Intimacy raises the possibility of being overwhelmed by powerful wishes to be taken care of, with the concomitant potential for frustration of those wishes, resulting in feelings of hatred and resentment and a desire for revenge. The feelings inherent to intimate relationships are threatening because they have the potential for becoming "out of control," one of the fundamental fears of the obsessive-compulsive person. Significant others frequently complain that their obsessive-compulsive loved one is too controlling. Stalemates and impasses often occur in such relationships because obsessive-compulsive persons refuse to acknowledge that anyone else might have a better way to do things. This need to control others often stems from a fundamental concern that sources of nurturance in the environment are highly tenuous and may disappear at any moment. Somewhere in every obsessive-compulsive person is a child who feels unloved. The low self-esteem connected with this childhood sense of not being valued often leads to an assumption that others would prefer not to put up with obsessive-compulsive persons. The high level of aggression and the intense destructive wishes lurking in the unconscious of the obsessive-compulsive person may also contribute to this

fear of losing others. These patients often fear that their destructiveness will drive others away or that it will lead to counteraggression, a projection of their own rage.

Despite OCPD patients' efforts to be dutiful, considerate, and compliant, the fear that they will alienate others often becomes a self-fulfilling prophecy. Obsessive-compulsive behavior tends to irritate and exasperate those who come in contact with it. The person displaying the behavior, however, may be perceived in somewhat different ways, depending on the power differential in the relationship (Josephs 1992). To subordinates, individuals with OCPD come across as domineering, hypercritical, and controlling. To their superiors, they may seem ingratiating and obsequious in a way that rings false. Ironically, then, the very approval and love they seek are undermined, and people with OCPD feel chronically unappreciated as they labor in their own tortured way to gain the longed-for approbation of others.

Obsessive-compulsive persons are also characterized by a quest for perfection. They seem to harbor a secret belief that if they can only reach a transcendent stage of flawlessness, they will finally receive the parental approval and esteem they missed as children. These children often grow up with the conviction that they simply did not try hard enough, and as adults, they chronically feel that they are "not doing enough." The parent who seems never satisfied is internalized as a harsh superego that expects more and more from the patient. Many obsessive-compulsive individuals become workaholics because they are unconsciously driven by this conviction that love and approval can be obtained only through heroic efforts to achieve extraordinary heights in their chosen profession. The irony in this striving for perfection, however, is that obsessive-compulsive persons rarely seem satisfied with any of their achievements. They appear driven more by a wish to gain relief from their tormenting superego than by a genuine wish for pleasure.

These dynamic underpinnings lead to a characteristic cognitive style (Horowitz 1988; Shapiro 1965). Whereas hysterical and histrionic patients tend to overvalue affective states at the expense of careful thought, the reverse is true for obsessive-compulsive persons. Not unlike Mr. Spock of *Star Trek* fame, obsessive-compulsive individuals seek to be thoroughly rational and logical in every endeavor. They dread any situation of uncontrolled emotion, and their mechanistic tendency to be totally without affect may drive those around them to distraction. Moreover, their thinking is logical only within certain narrow parameters. Their thought patterns can be characterized as rigid and dogmatic (Shapiro 1965). Dynamically, these qualities can be understood as compensatory for the underlying self-doubt and ambivalence that plague the obsessive-compulsive person.

In contrast with the cognitive style of the hysterical patient, that of the obsessive-compulsive individual involves careful attention to detail but an

almost complete lack of spontaneity or flexibility, with impressionistic hunches being automatically dismissed as "illogical." Obsessive-compulsive persons expend extraordinary energy to maintain their rigid cognitive and attentional styles so that absolutely nothing they do is without effort. A set of maladaptive beliefs haunts the person with OCPD. Among these are the following: "It is important to do a perfect job on everything"; "Any flaw or defect of performance may lead to a catastrophe"; "People should do things my way"; "Details are extremely important" (Gabbard and Newman 2005). Taking vacations, or even relaxing, generally holds no allure whatsoever for the true obsessive-compulsive person.

Although many of these individuals are high achievers, some find that their character style impairs their ability to succeed at work. Obsessive-compulsive persons may ruminate endlessly about small decisions, exasperating those around them. They often get bogged down in details and lose track of the main purpose of the task at hand. Their indecision may be dynamically related to deep feelings of self-doubt. They may feel that the risk of making a mistake is so great as to preclude a definite decision one way or another. Similarly, their concern that the final outcome of a project may be less than perfect may contribute to their indecisiveness. Many obsessive-compulsive persons are extraordinarily articulate verbally but encounter major psychological obstacles in their writing because of this concern that the end result will not be flawless.

The "driven" quality inherent in the actions of the obsessive-compulsive person has been well described by Shapiro (1965) as having "the appearance of being pressed or motivated by something beyond the interest of the acting person. He does not seem that enthusiastic. His genuine interest in the activity, in other words, does not seem to account for the intensity with which he pursues it" (p. 33). These patients are always driven by their own internal overseer who issues commands about what they "should" or "ought to" do. Dynamically speaking, they have little autonomy from their own superego injunctions. They behave the way they do because they must, regardless of how their behavior impinges on others.

The hypertrophied superego of the obsessive-compulsive patient is relentless in its demands for perfection. When those demands are not satisfied over a long period, depression may set in. This dynamic link between the obsessive-compulsive character and depression has been observed by clinicians for many years. The obsessive-compulsive person may be at particularly high risk for depression in middle age, when the idealistic dreams of youth are shattered by the reality of time running out with advancing age. These patients may become suicidal at this point in their life cycle and may require hospitalization despite a long history of functioning reasonably well in a work situation. Many of the perfectionistic depressed patients described

in Chapter 8 as having particularly treatment-resistant illness are driven by obsessive-compulsive personality characteristics.

As described in Chapter 8, depression is often linked to a sense that one is falling short of what one should be or should do. This perfectionistic tendency to judge oneself as always falling short is also associated with anxiety. Many patients with OCPD describe anxiety that keeps them awake at night as they try to figure out how to get everything on their agenda completed within a specific time frame. Perfectionism works against task completion, so they start to think about what else they can sacrifice to get their work done.

Although many people with OCPD assume that they are following a "script" written by their parents, there are clearly genetic factors at work as well. In a study of 292 young adult same sex female twins from the Michigan State University Twin Registry (Moser et al. 2012), both anxiety and maladaptive perfectionism were found to be moderately heritable, with estimates ranging from 0.45 to 0.66. The authors suggested that genetic factors were primarily responsible for the associations between the two measured entities. The same difficulties with anxiety and perfectionism may contribute to the problems that obsessive-compulsive individuals have in delegating tasks to others. The rigidity about how things should be done may make them convinced that only they can accomplish the task in the proper way. It is noteworthy in this regard that a finding in the Collaborative Longitudinal Personality Disorders Study (McGlashan et al. 2005) was that rigidity and problems delegating were the most prevalent and least changeable criteria over 2 years in OCPD patients.

The complex character structure of the patient with OCPD can be summarized as involving a public sense of self, a private sense of self, and an unconscious sense of self (Josephs 1992). Each of these has one dimension that is more applicable to superiors and another linked to relationships with subordinates. For example, the public sense of self in relationship to superiors is that of a responsible and conscientious worker who is serious, considerate, socially appropriate in all situations, and predictable. The public sense of self in relation to subordinates is that of a thoughtful mentor or constructive critic who is providing valuable feedback for those who will listen. Unfortunately, this subjectively experienced sense of public selfhood is not always what is perceived by others. The reactions of others, in fact, give rise to a private sense of self that is fully conscious but largely hidden from others. Patients with OCPD frequently have a sense that they are unappreciated and consequently feel hurt and angry. The lack of approval leads them to be tortured by self-doubt. This insecurity must be shielded from those in superior positions, because individuals with OCPD dread the humiliation and shame associated with having this self-doubting side of them exposed. They

are often convinced that others will see them as weak and whining. Existing side by side with this aspect of the private sense of self is a thorough conviction of moral superiority to those who are in subordinate positions. Because OCPD patients are so defended against their own sadism and aggression, they do not want to appear contemptuous. They attempt to mask this aspect of the private sense of self to avoid appearing pretentious, pompous, or hypercritical. They can then feel proud of how considerate and self-contained they are toward those "beneath them."

The two dimensions of the unconscious sense of self can be summarized as that of an obsequious masochist in relation to superiors and that of a controlling sadist in relation to subordinates (Josephs 1992). The sadistic and mean-spirited unconscious wish to inflict pain on those who do not submit to their control is entirely unacceptable to OCPD patients and must therefore be repressed. To do otherwise would be to compromise their high moral standards. In relationships with authority figures, on the other hand, these patients fear humiliation in the context of being submissive and longing for love, so they masochistically submit to their own excessively harsh moral standards and torture themselves for not living up to these expectations. This self-torture spares them from what they fear—namely, controlling, dominating, and sadistic humiliation by others. The unconscious message given to superiors is "There is no need for you to criticize and attack me, because you can see that I'm already tormenting myself mercilessly."

Psychotherapeutic Considerations

OCPD is often greatly improved by psychoanalysis or individual psychotherapy with an expressive emphasis (Gabbard and Newman 2005; Gunderson 1988; Horowitz 1988; McCullough and Maltsberger 2001; Munich 1986; Salzman 1980). Winston et al. (1994) described a controlled trial of 25 patients with Cluster C disorders who were treated in dynamic therapy, the mean length of which was 40.3 sessions. Although many patients require longer treatment, those in this sample improved significantly on all measures compared with control patients on a waiting list. Follow-up an average of 1.5 years after treatment completion demonstrated continued benefit. Research data also suggest that there may be ongoing improvements following the termination of therapy. As noted in Chapter 4, Svartberg et al. (2004) randomly assigned patients with Cluster C personality disorders to receive 40 weekly sessions of either dynamic therapy or cognitive therapy. The overall patient group showed statistically significant improvements in all measures during treatment and also during a 2-year follow-up period. Significant changes in symptom distress after treatment were found for the group who received dynamic psychotherapy but not for those who received cognitive

therapy. Two years after treatment, 54% of the dynamic therapy patients and 42% of the cognitive therapy patients had recovered symptomatically, whereas approximately 40% of the patients in both groups had recovered in terms of interpersonal problems and personality functioning. Whereas core personality pathology improved minimally during treatment, 2 years later improvement was evident in 35%–38% of the patients. Hence there was an "extended release" effect, suggesting that many patients internalized the therapeutic dialogue and continued to use it after termination.

In considering the resistances commonly encountered in the psychotherapy of obsessive-compulsive patients, one must first empathize with the implications that dynamic psychotherapy has for such patients. The very idea of the unconscious threatens their sense of control. To deal with the feeling of being threatened, the obsessive-compulsive person may discount all of the therapist's insights as "nothing new." Obsessive-compulsive patients may at first be reluctant to admit that the therapist is saying anything of which they are not already aware (Salzman 1980). Resistance can be understood as a patient's typical defensive operations as manifested in the psychotherapeutic process. These defenses include isolation of affect, intellectualization, undoing, reaction formation, and displacement. Isolation of affect, then, may present itself as a lack of awareness of any feelings toward the therapist, particularly dependency or anger. The patient may talk at great length about factual information from both past and present situations, with no apparent emotional reaction to these events. When the therapist returns from a lengthy vacation, the obsessive-compulsive patient is likely to be reluctant to admit any emotional reaction to the separation. If reaction formation is a prominent defense, the patient will probably respond with: "Oh, no, I wasn't bothered by it. I just hope that you had a wonderful time and feel refreshed." Using the distinction between public, private, and unconscious presentations of the self, one could describe the chief resistance as attempting to hide the private sense of self behind the public presentation of self as dutiful and conscientious (Josephs 1992).

Obsessive-compulsive persons also respond to the threat of intense affect with obsessional rambling that serves as a smokescreen to mask their real feelings. More precisely, it may serve as an anesthetizing cloud that puts others to sleep. As the patient wanders farther and farther afield from the original point, the therapist may lose track of the thread that links the patient's associations and may begin to "tune out" the patient. Because these persons may experience thoughts as having as much power as actions, the patient may feel the need to undo what has already been said, as follows:

> During the weekend visit with my parents, I became somewhat irritated with my father. Well, I wouldn't really say that I was irritated, in the sense that I

truly felt any anger toward him. It's just that he sat and watched TV and seemed to have no interest in speaking to me. At one point, I had the thought of turning the TV off and confronting him, but of course I didn't really do that. I would never actually be that rude to anyone.

The rambling speech pattern typical of the obsessive-compulsive patient in psychotherapy features the frequent canceling of thoughts or wishes that have just been verbalized. In addition, an overinclusiveness of thinking leads the patient to bring in peripheral events that take the content of the rambling progressively farther from the main theme of the session.

Many obsessive-compulsive patients will attempt to become the "perfect patient." They may try to produce exactly what they think the therapist wants to hear, with the unconscious fantasy that they will finally get the love and esteem they feel they missed as children. As McCullough and Maltsberger (2001) noted, "The patient ritualizes the therapeutic encounter and is likely to fence the therapist in by never coming late, paying the fee immediately, and becoming superficially very 'good' in the service of boxing in the treatment" (p. 2346). Patients with OCPD have a good deal of difficulty learning that spontaneous comments, occasional lateness, or a tardy fee payment may help both members of the dyad deepen their understanding of the process. Because they are certain that any expression of anger will result in disapproval, they may consciously experience no anger while unconsciously expressing it by completely monopolizing the session. One obsessive-compulsive patient talked nonstop for 50 minutes, ceasing exactly on time, without ever letting the therapist get a word in edgewise. In this manner, the patient was able to express his anger without having to acknowledge any angry feelings.

Other obsessive-compulsive patients will manifest their resistance by recreating in the transference relationship with the therapist their power struggle with their parents.

Mr. MM was an obsessive-compulsive printer who came to psychoanalytic therapy twice a week. He initially presented as a rather submissive and passive "good boy" who was completely unable to express any anger within the therapy sessions. However, he developed a pattern of not speaking for approximately half of the 50-minute session and of not paying his bill. Although he denied any anger toward the therapist when this behavior was brought out in the open, he developed a pattern of venting his anger with an exit line. One day, after failing to voice anger about the therapist "staring" at him during the session, he strode to the door and said, "I guess you didn't catch my cold," referring to a previously expressed concern that he might give his therapist his cold. On another occasion, after he was confronted about his failure to pay his bill, he exited with the following comment: "Don't freeze to death!" Shortly thereafter, another session ended with, "Don't slip on the ice!"

One of Mr. MM's most remarkable exit lines was delivered after a session where he was largely silent except for an occasional comment on the failure

to pay his bill. The therapist connected his failure to produce payment for the bill with his failure to produce verbal material for the sessions. After a prolonged silence, Mr. MM was informed that the time was up. As he went to the door, he turned to the therapist and said, "I almost bought you a book at a sale yesterday. It was by a physician and was entitled *Thirty Years of Rectal Practice.*" Then he rapidly left the room and slammed the door. During the next session, his therapist brought up this comment about his seemingly benevolent wish to buy him a gift. Mr. MM was able to explore his feeling that the therapist's attempt to extract money and words was comparable to an intrusive finger in his anus attempting to extract feces.

In the transference, Mr. MM had re-created a highly ambivalent relationship with his mother, which involved issues of withholding and control. He experienced his therapist as a mother who was demanding that he produce his feces (words and money) when and where she ordered him to. In order to defy what he felt was a sadistic and unreasonable command, he withheld his productions until the last moment, then let them go under his own control. In so doing, he attempted to make active what was passively experienced, venting his sadistic aggression in angry comments. However, as these examples illustrate, his characterological defense of reaction formation got the best of him in each exit line. Seeing through the reaction formation, the exit lines can be heard as follows: "Don't slip on the ice!" would be "I hope you slip on the ice." "Don't freeze to death!" would mean "I wish you would freeze to death." Even Mr. MM's attempt to equate his therapist with a sadistic and intrusive mother who was forcibly extracting his bodily contents had to be cloaked in the thought of buying him a gift. Despite the reaction formation, the anger in these exit lines still came through to the therapist. Because of Mr. MM's omnipotent concerns about the devastating power of his anger, he had to exit immediately after any hostile expression. He feared that his therapist would be so profoundly affected by these comments that he would retaliate in a massive and destructive fashion. Hence, Mr. MM could express his anger only as he left the office, out of danger from retaliation (Gabbard 1982).

Therapeutic approaches to address these characteristic resistances of obsessive-compulsive patients begin with careful attention to countertransference. The therapist may feel a strong pull to disengage from the rambling, mechanistic presentation of factual material. Therapists may begin to isolate affect just as the patient does rather than experience the irritation and anger as an important part of the process that needs to be interpreted to the patient. For example, when the therapist begins to feel bored and distanced by the material, a useful comment might be "Is it possible that you are presenting all this factual material as a way of keeping emotionally distant from me?" Another countertransference pitfall is for the therapist to scotomize certain aspects of the patient's psychopathology because of the therapist's

own obsessive-compulsive tendencies. Because obsessive-compulsive traits are highly adaptive in getting through medical school and psychiatry residency training (Gabbard 1985), therapists may be prone to overlook how these same traits might negatively affect a patient's relationships. To acknowledge the relational consequences of obsessive-compulsive tendencies may make therapists feel uncomfortable because the patient's situation may resonate with similar trends in the therapist's own personal relationships.

One effective strategy in the psychotherapeutic treatment of patients with obsessive-compulsive character structure is to cut through the smokescreen of words to go directly after feelings. The therapy process will frequently get bogged down in the patient's search for facts to avoid feelings, as in the following example:

> Mr. NN was a 29-year-old graduate student who sought psychotherapy. His chief complaint was of not being able to complete his dissertation. His therapist was a psychiatry resident slightly younger than him. In the first few sessions, the patient struggled with his concern about the therapist's age by attempting to establish certain facts.
>
> MR. NN: You look like you're probably not old enough to be a fully trained psychiatrist. I would guess you're approximately the same age as me. Is that correct?
> THERAPIST: Yes. I'm approximately the same age as you.
> MR. NN: I assume, of course, that you've had considerable training in psychotherapy. Isn't that correct?
> THERAPIST: Yes, I have.
> MR. NN: How long is a psychiatry residency anyway?
> THERAPIST: Four years.
> MR. NN: And what year are you in?
> THERAPIST: I'm in my third year.
> MR. NN: I guess you probably have a supervisor, though, don't you?
>
> At this point, the resident became aware that this question-and-answer approach was bypassing the patient's feelings. Instead of merely answering all the patient's factual questions, the therapist chose to address the process itself.
>
> THERAPIST: Mr. NN, it seems to me that this attempt to establish the facts of my training is a way of not addressing the feelings you're having about seeing a therapist who is approximately your own age and who is in training. I wonder if there isn't some anger and possibly even a bit of humiliation about having been assigned to a resident.

This vignette illustrates how the therapist should forthrightly address the patient's feelings even when the patient is denying their existence. Obsessive-

compulsive patients will also flee from transference feelings by retreating into long discourses about historically distant events. The therapist may have to bring the patient back to the here and now in the transference and attempt to establish what is going on in the present situation that caused the patient to seek refuge in the past (Salzman 1980, 1983). By keeping certain overarching themes and goals of the treatment in mind, often those with which the patient originally came to treatment, the therapist can maintain anchoring points for the process (Salzman 1980, 1983). When the patient endlessly ruminates about seemingly irrelevant minutiae, the therapist may have to interrupt the ruminations and bring the patient back to the central theme or issue that began the session. Group psychotherapy is often highly effective in dealing with this problem, because the patient may accept such feedback from peers without the same power struggle that accompanies feedback from the therapist.

Conflicts surrounding feelings are at the core of the dynamic psychotherapy of OCPD. There is guilt over anger, embarrassment about crying, pain and anxiety over intimacy, and shame about one's shortcomings. A focus on affect phobia has become a systematic approach to OCPD and other Cluster C personality disorders (Svartberg and McCullough 2010; Towne et al. 2012). The main objectives involve restructuring defenses by identifying patterns of avoidance of unconscious conflicted feelings, restructuring affect through exposure and desensitization, and building an adaptive sense of self and others by reducing shame associated with self-image, lowering expectations, and encouraging exposure to positive feelings. The therapist must track the patient's affect verbally and nonverbally and note any defenses marshaled against the affect and point them out as they occur. In this approach, it is also essential to help the patient experience feelings in the here and now rather than simply talking about them as abstractions. Rigorous research has clarified which kinds of therapist interventions are most helpful in dealing with affect phobia (Town et al. 2012). Compared with self-disclosure, asking questions, or providing information, the therapist's use of confrontation, clarification, and support resulted in much higher levels of immediate affect. These processed data were derived from studying hours of videotaped sessions with six cases of short-term dynamic psychotherapy. Confrontational interventions that attempt to direct pressure toward either the visceral experience of affect or the defenses used by the patient against feelings led to the highest levels of immediate affect experiencing.

In addition to confronting and interpreting the patient's characteristic defenses and helping the patient to express the feelings behind those defenses, another overall goal of the psychotherapy or psychoanalysis is to soften and modify harsh superego attitudes. In the simplest terms, this means that these patients must accept their humanness. They must accept

that their wish to transcend feelings of anger, hatred, lust, dependency, and so forth is doomed to failure. Feelings must finally be embraced as part of the human condition. They must be integrated as part of the person's self-experience rather than suppressed, denied, repressed, or disavowed as belonging to someone else. To accomplish this goal of making the superego a more benign structure, reassurance is rarely useful. Comments such as "You're not really as bad as you think you are" or "You're much too hard on yourself" will sound hollow to the patient.

Superego changes are more likely to occur through detailed interpretation of the patient's conflicts around dependency, aggression, and sexuality, in concert with the therapist's benign, helpful presence over time. By remaining nonjudgmental, the therapist helps the patient discover that his or her perceptions of the therapist are distorted according to templates forged by past relationships. Although the patient will repeatedly try to view the therapist as critical and judgmental, the therapist can help by pointing out that the patient is attributing his or her own critical, judgmental attitude to the therapist.

As these patients begin to understand that others are not nearly as critical as they themselves are, their self-esteem may correspondingly increase. They realize that others have accepted them all along much more than they had imagined. As they experience their therapist's acceptance of them for who they are, they also gain an increasing self-acceptance. As they learn that their conflicts over aggression and dependency stem from childhood situations, they gain greater mastery over these feelings and accept them as part of being human. The therapist can use periodic confrontations about the unrealistic expectations these patients so frequently harbor about themselves. One patient, for example, berated himself in a psychotherapy session over his feelings of rivalry with his older brother at a Christmas family gathering. The therapist commented, "You seem to believe that you should be able to transcend all feelings of competition with your brother and that you're a failure if you don't."

As in the psychotherapy of most patients, resistances are interpreted before underlying content. However, failure to respect the patient's defenses can lead to ill-advised, premature interpretations. Therapists who become irritated or exasperated and interpret the patient's private or unconscious sense of self may expose the patient in a way that feels terribly shaming or humiliating to him or her. If the therapist can contain countertransference irritation, the patient may start to express the private doubts and insecurities and the hidden contempt for others. Defenses against anger, such as reaction formation, may have to be addressed for some time before the patient can see the defensive pattern clearly enough to relate it to underlying anger. For example, the therapist might have to deliver an interpretation such as the follow-

ing: "Each time I announce a vacation, I notice that you say, 'No problem!' I wonder if that response covers up some other feelings that are more unacceptable." When obsessive-compulsive patients can finally experience and express undisguised anger toward the therapist, they learn that it is not nearly as destructive as they had thought. The therapist is a consistent, durable figure who is there week after week, clearly unscathed by expressions of anger. Similarly, these patients discover that they themselves are not transformed by their anger into destructive monsters.

Patients with OCPD tend to be tormented by "thought crimes." In the patient's unconscious, there is little difference between thinking an angry thought and punching someone in the nose. Part of the superego modification that takes place in dynamic therapy or psychoanalysis involves helping the patient to appreciate that hostile impulses, feelings, or thoughts are simply not the same as acts. The patient eventually learns that thoughts and feelings are not subject to the same moral standards as destructive actions. The acceptance of one's inner life also reduces anxiety.

To the obsessive-compulsive patient, sexual feelings are frequently just as unacceptable as anger or dependency. Again, the transference will be the forum for a reenactment of the childhood situation in which the patient sees the therapist as a parent who disapproves of sexuality. By avoiding a position of judgmental disapproval, the therapist allows the patient to eventually see that such prohibitions are internal, not external. The threat (of castration or loss of love) attributed to the therapist can be understood, then, as an illusory one emanating from within the patient.

A useful strategy in working with OCPD patients is to enlist their collaboration in an active exploration of how the obsessional thinking serves as a defense against loss (Cooper 2000). By ruminating about various alternatives to the point of paralyzing oneself with indecision, these patients may be avoiding giving anything up. They keep all possibilities alive by thinking that there are endless alternatives. This fantasy can be actively explored with patients, who may be helped to mourn the loss of having everything they desire. Many people with OCPD have underlying depressive themes, and it is no surprise that these patients have a relatively high prevalence of major depression (Skodol et al. 1999).

Finally, another key to successful psychotherapy or psychoanalysis with patients who have OCPD is empathy for the shame and guilt associated with the unacceptable aspects of the private sense of self and the unconscious sense of self that make these patients engage in self-loathing. Interventions acknowledging these patients' fear that others will discover their sadistic impulses, submissive longings, and pervasive insecurity may help create a holding environment in which the darker aspects of the psyche can be explored.

Avoidant Personality Disorder

The controversial category of avoidant personality disorder was designed to characterize a group of socially withdrawn individuals distinct from schizoid patients. Unlike schizoid patients (discussed in Chapter 14), avoidant patients long for close interpersonal relationships but are also afraid of them. These individuals avoid relationships and social situations because they fear the humiliation connected with failure and the pain connected with rejection. Their desire for relationships may not be readily apparent because of their shy, self-effacing self-presentation.

Considerable controversy exists regarding the distinction between generalized social phobia and avoidant personality disorder. Whereas there has been extensive research on social phobia, relatively few studies have focused on avoidant personality disorder, especially on treatment interventions. Reviews of the literature comparing social phobia and avoidant personality disorder (Alden et al. 2002; Rettew 2000) concluded that from the perspective of phenomenology, demographics, etiology, course, and treatment, there is little evidence of substantial qualitative difference between the two disorders. Any differences between the two that can be detected appear to be related more to severity than to any symptomatic discrepancies.

The criteria for avoidant personality disorder (Box 19–2) are frequently identified in clinical populations. A Norwegian study (Torgersen et al. 2001) found it to be the most common personality disorder, with a prevalence of 5%, whereas the prevalence in the United States is 2.36% (Grant et al. 2004). However, the disorder is rarely the primary or sole diagnosis in clinical practice (Gunderson 1988). It is most commonly a supplementary diagnosis to another personality disorder or diagnosis. The centrality of shame in the avoidant patient provides a psychodynamic link with certain types of narcissistic patients (particularly the phenomenologically hypervigilant type and some of those described by Kohut). In fact, some data (Dickinson and Pincus 2003) suggest that hypervigilant narcissistic individuals may be misdiagnosed as avoidant personality disorder because they present overtly with considerable fears of relating to others, lack of confidence in initiating and maintaining social relationships, and fears of being ashamed or disappointed when their needs are not fulfilled within relationships. Both persons with avoidant personality disorder and hypervigilant narcissistic individuals have needs to be liked and accepted by others, but the quiet grandiosity and sense of entitlement typical of narcissistic personality disorder is not present in avoidant individuals. Moreover, the hypervigilant narcissistic person requires admiration regardless of whether it is earned.

Box 19–2. DSM-5 Criteria for Avoidant Personality Disorder

301.82 (F60.6)

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

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Psychodynamic Understanding

People can be shy and avoidant for a variety of reasons. They may have a constitutional predisposition to avoid stressful situations based on inborn temperament that is secondarily elaborated into their entire personality style (Gunderson 1988). The dimension referred to as *harm-avoidance* in the psychobiological model of Cloninger et al. (1993), for example, may be a common biological factor in most patients with avoidant personality disorder. Some research data suggest that the trait of shyness is of genetic-constitutional origin but that it requires a specific environmental experience to develop into a full-blown trait (Kagan et al. 1988). Nachmias et al. (1996) found that attachment status moderated the expression of temperamental inhibition. Children with biological vulnerabilities to be inhibited and shy showed greater autonomic arousal to strangers if they were insecurely attached than if they had secure attachment status. Adverse environmental experiences have also appeared in another study of students with avoidant personality disorder symptoms (Meyer and Carver 2000). Students with these symptoms reported significantly more negative childhood memories such as being isolated, rejected, and subject to adverse childhood social experiences. Shyness or avoidance defends against embarrassment, humiliation, rejection, and failure. As with any other form of anxiety, the psychodynamic meaning of the anxiety

must be explored to understand fully its origins with each individual patient. However, the psychotherapeutic and psychoanalytic treatment of individuals with these concerns often uncovers shame as a central affective experience.

Shame and self-exposure are intimately connected. What avoidant patients generally fear is any situation in which they must reveal aspects of themselves that leave them vulnerable. Whereas guilt involves concerns about punishment for having violated some internal rule, shame relates more to an assessment of the self as somehow inadequate, as not measuring up to an internal standard. In this sense, guilt is more closely related to the superego in the structural model, whereas shame is more closely connected to the ego ideal (see Chapter 2). Individuals with avoidant personality disorder may feel that social situations must be avoided because their inadequacies will be displayed for all to see. They may feel ashamed about many different aspects of themselves; for instance, they may perceive themselves as weak, unable to compete, physically or mentally defective, messy and disgusting, unable to control bodily functions, or exhibitionistic (Wurmser 1981).

Shame is etymologically derived from the verb "to hide" (Nathanson 1987), and the avoidant patient often withdraws from interpersonal relationships and situations of exposure out of a wish to "hide out" from the highly unpleasant affect of shame. Shame cannot be reductionistically linked with one developmental moment in the life of the child but seems instead to evolve from many different developmental experiences at various ages (Nathanson 1987). Apparently present from very early in life, shame certainly is evident at the onset of stranger anxiety around 8 months of age (Broucek 1982). It is also connected with feelings that arise from bladder and bowel accidents and from an internalization of the parental reprimands often associated with those accidents. The 2-year-old child who is exhilarated by romping in the buff may also develop shame when a stern parent stops such activity by insisting that the child get dressed (Gabbard 1983). All these developmental experiences may be reactivated in the avoidant patient upon exposure to a group of people or an individual who matters a great deal to the patient.

Attachment theory has much to offer our understanding of avoidant patients. Adults with an avoidant attachment style have generally felt rebuffed by parents or caregivers in childhood and are thus frightened to develop love relationships in adulthood (Connors 1997). They often have a sense that their developmental needs were excessive or inappropriate, and they have experienced a failure of adequate selfobject responses (Miliora 1998).

Psychotherapeutic Approaches

Although empirical research on dynamic therapy of avoidant personality disorder is limited, two different studies, both of which were mentioned ear-

lier in this chapter in the discussion of OCPD, suggest that this approach is useful. In the controlled study by Winston et al. (1994), patients with Cluster C personality disorders who were treated with dynamic therapy did better than subjects in a waiting-list control group. In the Svartberg et al. (2004) study, Cluster C patients did extremely well with dynamic therapy and continued to make further changes following termination.

In a study focused specifically on avoidant personality disorder, 62 patients with the condition were assigned to either 20 sessions of cognitive-behavioral therapy (CBT), 20 sessions of brief dynamic therapy, or a wait list control condition (Emmelkamp et al. 2006). Patients in both of the treatment conditions showed statistically significant improvements on measures of anxiety symptoms, avoidant behaviors, and core beliefs related to avoidance and dependency. However, at 6-month follow-up, the effects of CBT were superior to those of brief dynamic therapy for remission rates of avoidant personality disorder. Of the patients who received brief dynamic therapy, 36% still met criteria for avoidant personality disorder, whereas only 9% of the CBT patients did. Nevertheless, remission rates of 64% and 91%, respectively, are impressive.

Patients with avoidant personality disorder may be most responsive to expressive-supportive psychotherapy if it is combined with firm encouragement to expose oneself to the feared situation (Gabbard and Bartlett 1998; Sutherland and Frances 1995). This encouragement to face the feared situation must, of course, be linked with empathic appreciation of the embarrassment and humiliation associated with exposure. One might say that the therapy is expressive-supportive in the sense that the expressive elements involve exploring the underlying causes of shame and their linkages to past developmental experiences, whereas the supportive elements involve empathically based encouragement to confront the feared situation rather than retreating in fear from it. This approach may be combined with a selective serotonin reuptake inhibitor to address the biological temperament.

More of the anxieties and fantasies will be activated in the actual situation of exposure than in the defensive posture of withdrawal. This fact can be explained to these patients in an educational intervention to help them see the value of actively seeking out the feared situations. Therapists should be prepared for the patient to agree with the need to face feared situations but then fail to follow through on the task assignment. Avoidant patients may be afraid to bring this up in the therapy for fear of receiving disapproval and criticism from the therapist (Newman and Fingerhut 2005).

Initial exploratory efforts may be frustrating because avoidant patients will not be entirely sure what it is that they fear. Avoidant patients often resort to psychiatric clichés, such as "rejection." The therapist must seek more detail of actual situations to help the patient move beyond such vague expla-

nations for avoidance. The therapist may ask, "What was your actual fantasy of what your coworkers might think of you when you sat in the lunchroom with them yesterday?" Similarly, specific fantasies can be explored in the context of the transference. Avoidant patients usually have a good deal of anxiety about the exposure inherent in psychotherapy. When a patient blushes about something that has been verbalized, the therapist might ask, "Can you share with me what's embarrassing you right now? Is there some reaction that you imagine I'm having to what you just said?" By pursuing the details of specific situations, the patient will develop a greater awareness of the cognitive correlates of the shame affect.

Ms. OO was a 24-year-old nursing student who came to psychotherapy because she felt dissatisfied with her life, had difficulty establishing heterosexual relationships, and experienced anxiety in social situations. She described chronic problems with feeling timid and shy around men. Because she was exceptionally attractive, she was frequently asked out, but her anxiety about each date would escalate to the point where she had to drink alcohol to relax. She told her therapist that she felt at risk for developing a dependence on alcohol, because she was only able to "open up" to men when she was under the influence. Ms. OO also noted the same experience of anxiety when she found herself "loosening up" with other people, such as peers in nursing school.

She had tried group psychotherapy for several months but found herself tongue-tied and self-conscious in the group. She would rarely speak for fear of "saying the wrong thing." When she began missing group psychotherapy sessions, she rationalized her absence by saying that it did not matter because she was not participating anyway. Ms. OO decided to seek individual psychotherapy because she thought it would be easier to open up to one person instead of eight.

In her third session in psychotherapy, she began to fall silent frequently. The therapist was patient during these silences, but after a few more sessions, he noted that her silences seemed to occur when she was about to experience strong feelings. She acknowledged that she was terribly afraid of losing control when she became emotional. The therapist asked Ms. OO if she were concerned about his response to her expression of emotion. Ms. OO said that she felt certain he would criticize her and "shame" her for "acting like a baby."

At this point the therapist asked Ms. OO if this fear was based on any similar past experiences. She launched into an extensive description of how her father had treated her as a child. She said that he was "a big man who couldn't take criticism but could deal it out." Each time she brought home a report card, he would yell at her, demanding, "Why didn't you get an A?" She also remembered spilling her milk at the supper table and being severely reprimanded by her father, who railed at her, "Why can't you be more like your sister?" With considerable embarrassment, she said her father had never made her feel comfortable about being female. He teased her on the day of her first period by telling her she now had an excuse for being "bad" once a

month. She recalled being extraordinarily mortified and crying in her room for hours. When she came home one day full of excitement because she had been selected as a cheerleader, her father called her "conceited and spoiled." She held a strong conviction that she would never be able to measure up to her father's expectations.

At one point in the therapy, Ms. OO was talking about her difficulty in attending parties or other social situations. Again the therapist asked about past situations that might be related to this fear. Ms. OO remembered that when she had been a little girl, her mother would dress her up and take her over to a friend's house, and everyone would always comment on how "cute" she was. She remembered her sense of embarrassment at these compliments, as though she had been "showing off." As the therapist helped her explore that feeling further, she realized that to some extent she had enjoyed the exposure because she had received such positive feedback in contrast to the constant criticism from her father. The therapist encouraged her to attend some of the social functions to which she was invited to see what other associations came to mind during an anxiety attack.

When Ms. OO began socializing more without first becoming inebriated, she realized that she feared enjoying herself. If she enjoyed the compliments of the men who hovered around her at a social gathering, then she was convinced that she was "conceited and spoiled," just as her father had said. This conviction made her feel that she was a "bad girl."

The case of Ms. OO illustrates that success in interpersonal situations often may be feared every bit as much as failure. The thrill of an exhibitionistic display may automatically trigger earlier parental reprimands about "showing off." Many individuals with avoidant personality disorder fear that they will become intoxicated with themselves when they are in the spotlight. This dynamic is central to the experience of stage fright (Gabbard 1979, 1983). Coexisting with Ms. OO's fear of enjoying her moment at center stage was another fear that she would fall short of the high expectations she had set for herself. These expectations were internalized by living with a father who had excessively high expectations. In the therapy, she was eventually able to acknowledge her intense anger at her father for repeatedly shaming her and making her feel so conflicted about her sexuality and her femaleness. Miller (1985) noted a consistent connection between the inhibition of anger and the shame experience. Ms. OO could never freely express her anger at her father, and she felt ashamed of even having such feelings.

Dependent Personality Disorder

Dependency, like rejection, has become something of a psychiatric cliché. Everyone is dependent to some degree, and most patients in a clinical setting will have some conflict over their feelings of dependency. Particularly in

American culture, where a powerful myth centers on rugged individualism and independence, the word "dependency" is often used pejoratively. Yet self psychologists would argue that true independence is neither possible nor desirable (see Chapter 2). Most of us need various selfobject functions, such as approval, empathy, validation, and admiration, to sustain us and to regulate our self-esteem.

The DSM-5 category of dependent personality disorder (DPD) is meant to capture a dependency so extreme as to be pathological (Box 19–3). These individuals are unable to make decisions for themselves, are unusually submissive, are always in need of reassurance, and cannot function well without someone else to take care of them.

DPD, like avoidant personality disorder, is rarely used as a principal or single diagnosis. Various studies (Bornstein 1995; Loranger 1996; Skodol et al. 1996) have demonstrated high comorbidity rates for patients with DPD. Included among the conditions frequently found in conjunction with DPD are major depression, bipolar disorder, some anxiety disorders, and eating disorders. Skodol et al. (1996) suggested that there is no specific relationship between DPD and depression. DPD simply presents a set of maladaptive behaviors and traits that cut across a wide range of personality psychopathology and are related to a variety of types of psychological distress. Indeed, most studies demonstrate that a patient diagnosed with DPD will also meet criteria for several other personality disorders. Although more than 50% of patients diagnosed with DPD also receive the diagnosis of borderline personality disorder, the two diagnoses can be differentiated on the basis of key aspects of relationship patterns. Borderline patients react to abandonment with rage and manipulation, whereas dependent patients become submissive and clinging (Hirschfeld et al. 1991). Moreover, the intense and unstable quality of the borderline patient's relationships is not found in the relationships of persons with DPD.

A Norwegian survey found the prevalence of dependent personality disorder to be 1.5%, with the prevalence in women twice that in men (Torgerson et al. 2001). However, this fact may be related to entrenched gender stereotypes in the culture that suggest that dependency is more acceptable in women than in men and allow women to express dependency more floridly.

Psychodynamic Understanding

Although early psychoanalytic writers believed that problems with dependency were connected with disturbances during the oral phase of psychosexual development, this view is not widely held today (Gunderson 1988). Such a formulation has the same problem as other phase-specific explanations for psychopathology. A pervasive pattern of parental reinforcement for

Box 19–3. DSM-5 Criteria for Dependent Personality Disorder

301.6 (F60.7)

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (**Note:** Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

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dependency throughout all phases of development is more likely to be operative in the backgrounds of patients with DPD. One empirical study (Head et al. 1991) found that families of persons with DPD were characterized by low expressiveness and high control in contrast with families in a clinical control group and a healthy control group. Another study of early family environment (Baker et al. 1996) found that the families of patients with DPD were low in independence and high in control.

Insecure attachment is a hallmark of DPD, and studies of patients with DPD (West et al. 1994) have found a pattern of enmeshed attachment. Many of the patients grew up with parents who communicated in one way or another that independence was fraught with danger. They may have been subtly rewarded for maintaining loyalty to their parents, who seemed to reject them in the face of any move toward independence. Interpersonal depen-

dence also appears to have a modest genetic influence in addition to the environmental factors that contribute to the clinical picture (O'Neill and Kendler 1998); thus, a biological temperament may also be an etiological factor in the overall picture.

Bornstein (1993) stressed that dependency and passivity should not be automatically equated. The central motivation of patients with DPD is to obtain and maintain nurturant, supportive relationships. To accomplish this goal, they may engage in assertive and active behaviors that are quite adaptive. For example, DPD patients are more likely to ask for feedback on psychological tests, to solicit help when solving difficult problems in a laboratory setting, and to seek medical attention when physical symptoms occur.

A submissive stance toward others may have myriad meanings. Just as the avoidant patient shuns exposure as a result of multiply determined unconscious factors, the dependent patient seeks caretaking because of anxieties that lie beneath the surface. The clinician should ask each individual, "What is it about independence or separation that is frightening?" Dependent clinging often masks aggression. It may be viewed as a compromise formation in the sense that it defends against hostility that is also concomitantly expressed. As many mental health professionals know from firsthand experience, the person who is the object of the dependent patient's clinging may experience the patient's demands as hostile and tormenting.

Dependent behavior may also be a way to avoid the reactivation of past traumatic experiences. The therapist should explore with the patient any memories of past separations and their impact.

> Mr. PP was a 29-year-old married postal clerk. He had a long-standing dysthymic disorder and chronically complained of insomnia, lack of energy, difficulty making decisions, and anxiety. Nevertheless, he managed to show up at his job conscientiously, even though he found it difficult to take any initiative when it was expected of him. Prior to his psychiatric hospitalization for suicidal thoughts and wishes, Mr. PP had broken down in tears in front of his supervisor when he was told he was not doing his job properly.
>
> During the admission interview, Mr. PP expressed extreme concern about being away from his wife during the hospitalization, even though he realized that his suicidal wishes were dangerous enough to necessitate inpatient treatment. Mrs. PP explained that her husband had never liked to be away from her. He relied on her to make all decisions in the home, and he could not function very well without her. Almost immediately after being admitted, Mr. PP latched onto a female patient approximately his age and looked to her for guidance in the same way he had related to his wife. He ate all his meals with her and spent all his leisure time with her when he was not involved in treatment activities. He made no sexual overtures toward this other patient but simply reported that he felt safe in her company.

Mr. PP's history revealed a lifelong pattern of anxious dependency. He had always experienced considerable anxiety at the prospect of doing something alone or upon initiating any plan of action without consulting others. He had school phobia when he started elementary school, and his mother reported that he had cried until she would take him home. Similarly, at the age of 10, he had been sent to visit his uncle overnight and had cried so hard that his mother had had to return to the uncle's house and bring him home. When he graduated from high school, all of his friends in his peer group enlisted in the service, so he followed suit. Upon discharge from the service, they went to work for the post office, so he applied along with them. Any independent action on his part seemed to reactivate the painful anxiety associated with early separations. He behaved as though convinced that he would be abandoned for any autonomous behavior.

The origins of Mr. PP's dependency and separation anxiety became clearer when his mother began to call him in the hospital. She complained about his decision to enter the hospital: "How can you justify being away from us like this? Your condition can't be that bad. What if we need you to do something and you're not available?" The patient explained that even as an adult, he had responded to his mother's call to come over to her house each week to do various menial jobs. He went on to say that his parents were virtually noncommunicative with each other and that his mother had relied on him for conversation. Mr. PP had grown up in a household where his mother had conveyed a powerful message—namely, that she needed him as a stand-in for her emotionally estranged husband. Independence was thus regarded as an aggressive and disloyal act that would lead to the loss of his mother's love.

Psychotherapeutic Considerations

As noted previously in the chapter, two randomized controlled trials (Svartberg et al. 2004; Winston et al. 1994) suggest that 40 weekly sessions of dynamic psychotherapy are highly effective in the treatment of patients with Cluster C personality disorders. Patients with DPD tend to have a lower attrition rate than other personality disorders as well (Karterud et al. 2003; Shea et al. 1990). In using the affect phobia model (Svartberg and McCullough 2010), one would look for the underlying feelings of attachment to others as well as all the problems embedded in the sense of the relationship one has with others. Overindulgence by parents is one source of difficulty, which may create a combination of anger and dependency, often referred to as *hostile dependency.* Children who were given great independence or isolation early in life may also have anxiety about independence associated with insecure attachment and can behave in a clingy or dependent manner to deal with it. The psychotherapy of these patients presents an immediate therapeutic dilemma—for them to overcome their problems with dependency, they must first develop dependency on their therapist. This dilemma often becomes elaborated into a specific form of resistance in which

the patient sees dependency on the therapist as an end in itself rather than as a means to an end. After a period in therapy, these patients may forget the nature of the complaint that brought them to treatment, and their only purpose becomes the maintenance of their attachment to the therapist. Dreading termination, they may repeatedly remind their therapist of how awful they feel to ensure continuation of the treatment. If the therapist comments on any improvement whatsoever, the patient may paradoxically worsen because the thought of improvement is equated with termination.

One rule of thumb in treating dependent patients is to remember that what they say they want is probably not what they need. They will attempt to get the therapist to tell them what to do, to allow them to continue their dependency, and to collude in the avoidance of making decisions or asserting their own wishes. The therapist must feel comfortable in frustrating these wishes and instead promoting independent thinking and action in the patient. The therapist must convey that the anxiety produced by this frustration is tolerable and also productive in that it may lead to associations about the origins of the dependency and the fears associated with it.

Another common transference development is idealization of the therapist (Perry 2014). The patient may begin to regard the therapist as all-knowing and display a wish to turn over all responsibility for important decisions to the therapist. Often patients have the fantasy that the solution to all of their problems is to become just like the therapist. This wish to bypass the difficult work of finding an authentic sense of self separate from the therapist needs to be interpreted and confronted as the therapy progresses. The patient may even attempt to undermine therapeutic goals to demonstrate that he or she cannot think or function independently of the therapist.

Time-limited dynamic psychotherapy has been successful with a number of these patients (Gunderson 1988). Knowing from the beginning of the psychotherapy that the patient–therapist relationship will end after 12, 16, or 20 sessions forces these patients to confront their deepest anxieties about loss and independence. Moreover, this approach also helps patients address powerful fantasies involving the never-ending availability of nurturing figures. When long-term, open-ended therapy reaches something of a stalemate, a modification of the time-limited technique can be utilized by setting a deadline for termination. Anxieties that may have lain dormant will be brought rapidly to the surface when the end of therapy is in sight.

A subgroup of dependent patients are simply unable or unwilling to make use of the framework of brief psychotherapy. The prospect of losing the therapist after "just getting started" creates too much anxiety. Because of lesser amounts of ego strength or greater degrees of separation anxiety, these patients need to develop a positive dependent transference to a therapist over a long period of time. Nevertheless, considerable therapeutic gains are

possible with this supportive strategy, as documented by Wallerstein's (1986) research (discussed in Chapter 4). Some patients change as part of a "transference trade" (Wallerstein 1986, p. 690) with the therapist. They are willing to make certain alterations in their lives in return for the therapist's approval. Others may become "lifers" who can maintain change as long as they know that the therapist will always be there for them. These patients may do well even when the therapist tapers down the sessions to one every few months, provided there is no threat of termination (Gabbard 2009).

In the case of patients with DPD, cultural issues must be factored into the diagnostic understanding and taken into account in treatment planning. In some cultures, dependency is not only expected but praised as a form of loyalty to older members of the family. When family members accompany the patient to a consultation, there is an opportunity to understand at greater length the family and cultural views of dependency and incorporate them into the treatment. When increasing autonomy by the patient is experienced as a threat to the family, the therapist may wish to consider family therapy as an adjunct treatment (Perry 2005).

Patients with DPD commonly evoke countertransference problems related to dependency conflicts in their treaters. Physicians in general, and psychiatrists in particular, may feel conflicted about their own dependency (Gabbard 1985; Gabbard and Menninger 1988; Vaillant et al. 1972). Psychotherapists must be wary of countertransference contempt or disdain toward the dependent patient. The longings of the patient may resonate with the unconscious longings of the therapist, and an empathic attunement with such dependency wishes may be acutely uncomfortable. Therapists who repudiate their patient's longings may be repudiating their own longings as well. Other countertransference difficulties include enjoyment of the patient's idealization, leading the therapist to avoid confronting the patient's lack of real change (Perry 2014). Therapists may also become overly authoritarian and directive, particularly if the patient continues in abusive relationships and does not heed the therapist's warning that the relationship is destructive.

A basic axiom of psychodynamic psychotherapy is that it is noncoercive—no one can make anyone else do anything. Hence, a countertransference position to avoid is one in which the therapist is working harder than the patient on trying to get the patient to "grow up" or separate from the patient's family. The patient and the family may have reasons that they would prefer to stay together that are trumping any efforts by the therapist to help them separate. There is often a paradoxical effect of backing off from a position of trying to make the patient leave home and instead focusing on how the family sees the situation. In other words, the therapist may ask the family and patient, "What do you think about the possibility of just allowing the patient to continue living with the family?" This approach removes the therapist from the appear-

ance of trying to "pry" the patient out of the family system. It also facilitates the family and patient's introspection about what they really want and what they fear if there is any change. Today therapists commonly see "failure to launch" young adults who are embedded in a family system that is rife with anxieties. A thoroughgoing exploration of those fears may be the best and most nonjudgmental approach to the dependent patient.

Other Specified and Unspecified Personality Disorders

Having completed our survey of the DSM-5 personality disorders, it is worth noting that patients generally do not present as "pure cultures" of any one personality disorder. It is common for patients to present with traits or features of more than one DSM-5 personality disorder. In DSM-5 a clinician has two options in these situations. The category of *other specified personality disorder* is to be used in situations in which the clinician wishes to communicate the specific reason that the presentation does not meet the criteria for any specific personality disorder.

The alternative is *unspecified personality disorder,* in which symptoms of clinically significant distress or impairment in social or occupational areas of functioning are present but do not meet the criteria for any of the disorders in DSM-5. The unspecified personality disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for any one personality disorder. This category would include situations in which more information is needed

This discussion of personality features that do not fit pure categories is an auspicious note on which to end the text. The dynamic psychiatrist is intrigued by the uniqueness and the idiosyncrasies of the individual. In fact, dynamic psychiatrists are more interested in how patients differ from one another than how they are similar. This axiom is nowhere more relevant than in the situation with personality disorders. However, regardless of diagnosis, the dynamic psychiatrist is always treating both the person and the illness, knowing that the former will always affect the latter.

References

Abraham K: Contributions to the theory of the anal character (1921), in Selected Papers of Karl Abraham, MD. London, Hogarth Press, 1942, pp 370–392

Alden LE, Laposa JM, Taylor CT, et al: Avoidant personality disorder: current status and future directions. J Pers Disord 16:1–29, 2002

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Baer L, Jenike MA, Ricciardi JN, et al: Standardized assessment of personality disorders in obsessive-compulsive disorder. Arch Gen Psychiatry 47:826–830, 1990

Baker JD, Capron EW, Azorlosa J: Family environment characteristics of persons with histrionic and dependent personality disorders. J Pers Disord 10:81–87, 1996

Bejerot S, Ekselius L, von Konorring L: Comorbidity between obsessive-compulsive disorder (OCD) and personality disorders. Acta Psychiatr Scand 97:398–402, 1998

Bornstein RF: The Dependent Personality. New York, Guilford, 1993

Bornstein RF: Comorbidity of dependent personality disorder and other psychological disorders: an integrative review. J Pers Disord 9:286–303, 1995

Broucek FJ: Shame and its relationship to early narcissistic developments. Int J Psychoanal 63:369–378, 1982

Cloninger CR, Svrakic DM, Pryzbeck TR: A psychobiological model of temperament and character. Arch Gen Psychiatry 50:975–990, 1993

Connors ME: The renunciation of love: dismissive attachment and its treatment. Psychoanalytic Psychology 14:475–493, 1997

Cooper S: Obsessional thinking: the defence against loss. Br J Psychother 16:412–422, 2000

Diaferia G, Bianchi I, Bianchi ML, et al: Relationship between obsessive-compulsive personality disorder and obsessive-compulsive disorder. Compr Psychiatry 38: 38–42, 1997

Dickinson KA, Pincus AL: Interpersonal analysis of grandiose and vulnerable narcissism. J Pers Disord 17:188–207, 2003

Emmelkamp PM, Benner A, Kuipers A, et al: Comparison of brief dynamic and cognitive-behavioral therapies in avoidant personality disorder. Br J Psychiatry 189:60–64, 2006

Freud S: Character and anal erotism (1908), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 9. Translated and edited by Strachey J. London, Hogarth Press, 1959, pp 167–175

Gabbard GO: Stage fright. Int J Psychoanal 60:383–392, 1979

Gabbard GO: The exit line: heightened transference-countertransference manifestations at the end of the hour. J Am Psychoanal Assoc 30:579–598, 1982

Gabbard GO: Further contributions to the understanding of stage fright: narcissistic issues. J Am Psychoanal Assoc 31:423–441, 1983

Gabbard GO: The role of compulsiveness in the normal physician. JAMA 254:2926–2929, 1985

Gabbard GO: What is a "good enough" termination? J Am Psychoanal Assoc 57:575–594, 2009

Gabbard GO, Bartlett AB: Selective serotonin reuptake inhibitors in the context of an ongoing analysis. Psychoanalytic Inquiry 18:657–672, 1998

Gabbard GO, Menninger RW: The psychology of the physician, in Medical Marriages. Edited by Gabbard GO, Menninger RW. Washington, DC, American Psychiatric Press, 1988, pp 23–38

Gabbard GO, Newman CF: Psychotherapy of obsessive-compulsive personality disorder, in Oxford Textbook of Psychotherapy. Edited by Gabbard GO, Beck J, Holmes JA. Oxford, England, Oxford University Press, 2005

Grant BF, Hasin DS, Stinson FS, et al: Prevalence, correlates and disability of personality disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry 65:948–958, 2004

Gunderson JG: Personality disorders, in The New Harvard Guide to Psychiatry. Edited by Nicholi AM Jr. Cambridge, MA, Belknap Press, 1988, pp 337–357

Head SB, Baker JD, Williamson DA: Family environment characteristics and dependent personality disorder. J Pers Disord 5:256–263, 1991

Hirschfeld RMA, Shea MT, Weise R: Dependent personality disorder: perspectives for DSM-IV. J Pers Disord 5:135–149, 1991

Horowitz MJ: Introduction to Psychodynamics: A New Synthesis. New York, Basic Books, 1988

Jones E: Anal-erotic character traits, in Papers on Psycho-Analysis, 5th Edition. Baltimore, MD, Williams & Wilkins, 1948, pp 413–437

Josephs L: Character Structure and the Organization of the Self. New York, Columbia University Press, 1992

Kagan J, Reznick JS, Snidman N: Biological bases of childhood shyness. Science 240: 167–171, 1988

Karterud S, Pedersen G, Bjordal E, et al: Day treatment of patients with personality disorders: experiences from a Norwegian treatment research network. J Pers Disord 17:243–262, 2003

Loranger AW: Dependent personality disorder: age, sex, and Axis I comorbidity. J Nerv Ment Dis 184:17–21, 1996

McCullough PK, Maltsberger JT: Obsessive-compulsive personality disorder, in Treatments of Psychiatric Disorders, Vol 2, 3rd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2001, pp 2341–2352

McGlashan TH, Grilo CM, Sanislow CA, et al: Two-year prevalence and stability of individual DSM-IV criteria for schizotypal, borderline, avoidant and obsessive-compulsive personality disorders: toward a hybrid model of Axis II disorders. Am J Psychiatry 162:883–889, 2005

Menninger WC: Characterologic and symptomatic expressions related to the anal phase of psychosexual development. Psychoanal Q 12:161–193, 1943

Meyer B, Carver CS: Negative childhood accounts, sensitivity, and pessimism: a study of avoidant personality disorder features in college students. J Pers Disord 14:233–248, 2000

Miliora MT: Facial disfigurement: a self-psychological perspective on the "hide-and-seek" fantasy of an avoidant personality. Bull Menninger Clin 62:378–394, 1998

Miller S: The Shame Experience. Hillsdale, NJ, Analytic Press, 1985

Moser JS, Slane JD, Burt SA, et al: Etiologic relationships between anxiety and dimensions of maladaptive perfectionism in young adult female twins. Depress Anxiety 29:47–53, 2012

Munich RL: Transitory symptom formation in the analysis of an obsessional character. Psychoanal Study Child 41:515–535, 1986

Nachmias M, Gunnar M, Mangelsdorf S, et al: Behavioral inhibition and stress reactivity: the moderating role of attachment security. Child Dev 67:508–522, 1996

Nathanson DL: A timetable for shame, in The Many Faces of Shame. Edited by Nathanson DL. New York, Guilford, 1987, pp 1–63

Newman CF, Fingerhut R: Psychotherapy for avoidant personality disorder, in Oxford Textbook of Psychotherapy. Edited by Gabbard GO, Beck JS, Holmes JA. Oxford, England, Oxford University Press, 2005

O'Neill FA, Kendler KS: Longitudinal study of interpersonal dependency in female twins. Br J Psychiatry 172:154–158, 1998

Perry JC: Dependent personality disorder, in Oxford Textbook of Psychotherapy. Edited by Gabbard GO, Beck J, Holmes JA. Oxford, Oxford University Press, 2005

Perry JC: Cluster C personality disorders: avoidant, obsessive-compulsive and dependent, in Gabbard's Treatment of Psychiatric Disorders, 5th Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Publishing, 2014

Rasmussen SA, Tsuang MT: Clinical characteristics and family history in DSM-III obsessive-compulsive disorder. Am J Psychiatry 143:317–322, 1986

Rettew DC: Avoidant personality disorder, generalized social phobia, and shyness: putting the personality back into personality disorders. Harv Rev Psychiatry 8: 283–297, 2000

Rosen KV, Tallis F: Investigation into the relationship between personality traits and OCD. Behav Res Ther 33:445–450, 1995

Salzman L: The Obsessive Personality: Origins, Dynamics, and Therapy. New York, Science House, 1968

Salzman L: Treatment of the Obsessive Personality. New York, Jason Aronson, 1980

Salzman L: Psychoanalytic therapy of the obsessional patient. Curr Psychiatr Ther 22:53–59, 1983

Samuels J, Nestadt G, Bienvenu OJ, et al: Personality disorders and normal personality dimensions in obsessive-compulsive disorder. Br J Psychiatry 177:457–462, 2000

Shapiro D: Neurotic Styles. New York, Basic Books, 1965

Shea MT, Pilkonis PA, Beckham E, et al: Personality disorders and treatment outcome in the NIMH Treatment of Depression Collaborative Research Program. Am J Psychiatry 147:711–718, 1990

Skodol AE, Gallaher PE, Oldham JM: Excessive dependency and depression: is the relationship specific? J Nerv Ment Dis 184:165–171, 1996

Skodol AE, Stout RL, McGlashan TH, et al: Co-occurrence of mood and personality disorders: a report from the Collaborative Longitudinal Personality Disorders Study (CLPS). Depress Anxiety 10:175–182, 1999

Sutherland SM, Frances A: Avoidant personality disorder, in Treatments of Psychiatric Disorders, Vol 2, 2nd Edition. Edited by Gabbard GO. Washington, DC, American Psychiatric Press, 1995, pp 2345–2353

Svartberg M, McCullough L: Cluster C personality disorders: prevalence, phenomenology, treatment effects, and principles of treatment, in Psychodynamic Psychotherapy for Personality Disorders: A Clinical Handbook. Edited by Clarkin JF, Fonagy P, Gabbard GO. Washington, DC, American Psychiatric Publishing, 2010, pp 337–367

Svartberg M, Stiles TC, Seltzer MH: Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for Cluster C personality disorders. Am J Psychiatry 161:810–817, 2004

Torgersen S, Kringlen E, Cramer V: The prevalence of personality disorders in a community sample. Arch Gen Psychiatry 58:590–596, 2001

Town JM, Hardy GE, McCullough L, et al: Patient affect experiencing following therapist interventions in short-term dynamic psychotherapy. Psychother Res 22:208–219, 2012

Vaillant GE, Sobowale NC, McArthur C: Some psychologic vulnerabilities of physicians. N Engl J Med 287:372–375, 1972

Wallerstein RS: Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy. New York, Guilford, 1986

West M, Rose S, Sheldon-Keller A: Assessment of patterns of insecure attachment in adults and application to dependent and schizoid personality disorders. J Pers Disord 8:249–256, 1994

Winston A, Laikin M, Pollack J, et al: Short-term psychotherapy of personality disorders. Am J Psychiatry 151:190–194, 1994

Wurmser L: The Mask of Shame. Baltimore, MD, Johns Hopkins University Press, 1981

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